Palm Desert Psychiatry
74-075 El Paseo Palm Desert, CA 92260
Tel (760) 668-5598 ▫ Fax (805) 439-1070
www.palmdesertpsychiatry.com

HIPPA RELEASE FORM

I, _____ **(Patient Name),** _____ **(DOB)** herby authorize Palm Desert Psychiatry, Inc. For purpose of the following **(Please Check One):**

____ Release medical records to: ____ Discuss with:

____ Obtain medical records from: ____ Release/Obtain/Discuss with:

Name:_____ **Phone number:** _____

Address:_____

The following information: **(Please check all that apply)**

___ All Information ___ Outpatient Records ___ Diagnostic Tests

___ Medical Consultation ___ Psychiatric Evaluation ___ Progress notes

___ Other: _____

I authorize disclosure of information which refers to treatment or diagnosis of drug or alcohol abuse, I understand that it cannot be re-disclosed by a recipient without specific consent. I authorize disclosure of information which refers to treatment or diagnosis of HIV infection, ARCS or AIDS. I understand I may review such information prior to its release (the review may be supervised).

I understand that individuals about whom such disclosures have been made encountered discrimination from others in the areas of employment, housing, education, life insurance, and social and family relationships. I understand that I can refuse to disclose some information in my treatment records, but if I do so, could result in improper diagnosis, improper treatment, denial of coverage on claims, or other insurance and adverse consequences. I further understand that such information to be disclosed may include treatment of psychiatric, substance abuse and HIV/AIDS related illnesses. I can revoke all or part of this authorization, in writing at any time by delivering a written, dated and signed notification to the office of Dr. Pedro Guimaraes. I am entitled to a copy of this authorization, upon request. I can cross out any provision on this form with which I disagree. This authorization is effective until _____ **(date not to exceed one (1) year)**. I authorize future disclosures regarding these records in the same individuals and or entitles during this time period.

_____ _____ _____

Print Patient name/Authorized Representative Signature of Patient/Authorized Representative Date

_____ _____ _____

Printed Name of Witness Signature of Witness Date