Yanira M. Olaya M.D., Inc.
Board Certified in General and Forensic Psychiatry
7590 Fay Ave. Ste. 501
La Jolla, CA 92037
T. 619-717-8833 F. 619-717-8888

Authorization To Release Healthcare Information

Patient Name: _____ Birth Date:_____

Address: _____ Daytime Telephone:_____

_____ SSN#:_____

I hearby authorize and request release of my medical records:

From:_____
_____

To:_____
_____

Dates of Authorization of Information to be disclosed:

From (date)_____to (date)_____

__Discharge Summary __Psychiatric Progress Note/Clinical Notes

__History and Physical Examination __Laboratory Results

__Initial Psychiatric Assessment __Radiology Results

__Other (Please specify): _____
_____
_____

Purpose of Release: __Psychiatric care __Transferring care __coordinate care with other providers __Discuss my care with friends or family that may provide support

At any time before disclosure of the information, this statement can be revoked. If no date of expiration is provided by the patient, then the authorization expires 12 months after it is signed.

I understand that the individual/institution that receives the information described above may not be covered by federal privacy regulations, and that the information may be re-disclosed publicly and no longer be protected by those regulations.

Signature of Patient: _____

Signature of Parent, Guardian or authorized representative: _____

Today's Date: _____