Redwood PsychAlliance, Inc.
509 7th Street, Suite 100, 1st Floor
Santa Rosa, CA 95401-5265
Phone: 707.568.1101 / Fax: 707.568.1103

[ ] Lorette Labataille, MD
[ ] Dagmar Hoheneck-Smith, MD
[ ] Bonnie Beem, LMFT
[ ] Robert Greenberg, LMFT
[ ] Elaine Greenwood, LMFT

AUTHORIZATION TO RELEASE, OBTAIN OR EXCHANGE HEALTHCARE INFORMATION

Patient: _____ DOB: _____

Other Name(s): _____Social Sec.#: _____

Telephone#: _____Cell #: _____

I authorize, Redwood PsychAlliance, Inc. to: **release, exchange or obtain** any information from my medical records including progress reports, treatment, diagnosis, and laboratory test results or claims information. This information may be **released, exchanged or obtained from or to the following:**

[ ] Spouse: _____ (Number) _____

[ ] Parents: _____ (Number) _____

[ ] Physician: _____ (Number) _____

[ ] Therapist: _____ (Number) _____

[ ] Children: _____ (Number) _____

[ ] Other: _____ (Number) _____

Duration: This authorization shall become effective immediately and shall remain in effect for one (1) year from the date of signature unless a different date is specified here: (Date) _____

Revocation: This authorization is subject to written revocation by the patient at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or others have acted in reliance upon this authorization.

Disclosure: I understand that the recipient may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

[ ] All healthcare information
[ ] Healthcare information relating to the following treatment, condition or date: _____
[ ] Other: _____

Patient/Parent or Guardian Signature: _____ Date: _____