San Diego ADHD Center

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Telephone: (858) 481-4988 * FAX (858) 400-5204

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ hereby authorize **Dr. Lori Rappaport** and the following to disclose information and/or records regarding myself or:

(Name of patient)_____ (Date of Birth)_____

Physician/Pediatrician:_____ Phone/Email:_____

Psychiatrist:_____ Phone/Email:_____

Teacher:_____ Phone/Email:_____

Other:_____ Phone/Email:_____

Other:_____ Phone/Email:_____

Other:_____ Phone/Email:_____

The following information may be disclosed:

_____All pertinent records/information reports
_____Psychological/Psychiatric treatment reports
_____Medical records
_____Educational/School records
_____Diagnostic impressions
_____Letter requested by patient (specify):
_____

_____Psychological testing reports
_____Hospital records
_____Family history
_____Laboratory tests
_____Treatment Summary
_____ Billing Records
_____Other (specify)_____

Disclosure of records is required for the following purposes:

_____Psychological treatment
_____Medical evaluation
_____Case review/Consultation
_____Court Request
_____ ADHD Evaluation
_____Emergency Only
_____Educational Planning
_____Personal
_____Other (describe) _____

In addition, I hereby authorize Dr. Lori Rappaport to provide information, both oral and/or written, upon request, to the above stated person or agency.

NOTICE OF PROVIDER'S RIGHT TO WITHHOLD INFORMATION

The representative of a minor patient shall not be entitled to inspect or receive copies of a minor's patient records with respect to records for which the minor has a right of inspection or where the health care provider determines that access to the patient records requested by the representative would have a detrimental effect on the provider's professional relationship with the minor patient or the minor's physical safety or psychological well-being. Provider may also choose to prepare a summary of the record rather than allowing access to the entire record. If Provider determines there is a substantial risk of significant adverse or detrimental consequences to the patient in seeing or receiving a copy of the mental health records requested above, Provider may decline to permit inspection or provide copies of the requested records. In such event, Provider will make a written record noting the date of this request and explaining Provider's reason for refusing to permit inspection or provide copies of the records, including a description of the specific adverse detrimental consequences that Provider anticipates would occur to patient if inspection or copying were permitted. Provider shall permit inspection by or provide copies of the requested records to a licensed physician, licensed psychologist or other licensed behavioral health professional designated by patient.

NOTICE OF RISK OF REDISCLOSURE

If you authorize the disclosure of health information to someone who is not legally required to keep it confidential, it may be potentially redisclosed and may no longer be protected.

This consent shall automatically terminate one (1) year from the date of signing or on _____ , unless previously revoked as set forth below.

NOTICE OF RIGHT OF REVOCATION

You may revoke this authorization at any time. Your revocation must be in writing, signed by you or your legal representative, and delivered to Dr. Lori Rappaport at her office address. You may deliver your revocation by any means you choose such as by personal delivery or U.S. Mail, but *not* by email, text messaging, or facsimile. Your revocation will be effective only when it is actually received. Your revocation will not be effective to the extent that Dr. Lori Rappaport or others have already acted in reliance upon this authorization.

_____ _____

Patient's Signature Date

_____ _____

Parent, Guardian or Authorized Representative of Patient Date

_____

Relationship-if signed by other than Patient