DR. SHEILA KHALEGHIAN

CLINICAL PSYCHOLOGIST

AUTHORIZATION FOR REQUEST OF MEDICAL DATA

Release To: _____ Phone #:_____ Fax #:_____

Release To: _____ Phone #:_____ Fax #:_____

Reason for Request: _____

Patient's name: _____

Birth Date: _____ Phone #:_____

☐ I hereby authorize _____ to furnish the above named individual or company all medical data regarding diagnosis, laboratory reports, imaging studies, care and treatment for alcohol abuse or drug abuse or mental health from _____ to present or _____.

Indicate limitations, if any, of medical information requested and/or restrictions, if any, of how such information is to be used:

_____

_____

This consent is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance hereon and if not earlier revoked it shall terminate one year from date of consent without express revocation. The patient may receive a copy of this authorization if requested.

_____ _____

Date Patient Signature

_____

Parent or Legal Guardian

(310) 955-0435 | info@drktherapy.com | www.drktherapy.com

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