HAMLIN EMORY, M.D.
2080 Century Park East, Suite 1409
Los Angeles, CA 90067
Tel: (310) 277-7711 Fax: (310) 277-7723

CONSENT TO RELEASE MEDICAL, PSYCHIATRIC OR ALCOHOL/DRUG ABUSE PATIENT RECORDS

I hereby authorize:

Name: _____

Street: _____

City: _____ State _____ Zip _____

Phone: _____

Fax: _____

to disclose the records of:

Patient Name: _____

Date of Birth: _____

Street: _____

City: _____ State _____ Zip _____

These records having been obtained in the course of diagnosis and treatment for medical disorders, psychiatric reasons, alcohol abuse and/or drug abuse and to *send these records to*:

Dr. W. Hamlin Emory
2080 Century Park East, Suite 1409
Los Angeles, CA 90067

The disclosure of records authorized herein is required for the following purpose: _____

_____

and such disclosure shall be limited to the following specific types of information: _____

_____

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 on: _____

(date, event, or condition on which consent will terminate)

Note:
Federal Regulation requires that all blanks must be completed INCLUDING date, event, or condition on which consent will terminate.

STATE OF CALIFORNIA – Division 5 #5327 and #5328 WNI (Welfare and Institution) Code – releasable under Public Law 93-579.

A copy of this release (please check one box): ☐ is / ☐ is not given to the patient.

_____
Signature of Patient

_____
Signature of Authorized Person

_____
Date

_____
Witness