Frances Wren MD
Psychiatry and Psychotherapy for adults, adolescents and children
550 Hamilton Avenue, Suite 305, Palo Alto CA 94301. (650) 521-0028

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Completion of this form authorizes the use or disclosure of health information about you or your child.

Name of patient:_____

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize **Frances Wren MD** to release to_____
(persons/organizations authorized to ***receive*** the information)

of _____
(Address, street, city, state, zip code)

A. All health information pertaining to medical history, mental or physical condition & treatment . _____
OR (initial)

B. Only the following records or types of information (including any dates) _____
_____ (initial)

_____

AND

C. I specifically authorize the release of the following information (initial as appropriate)

- **Mental health treatment information** **_____(initial)**
- HIV/AIDS test results _____(initial)
- Alcohol/drug treatment information _____(initial)

PURPOSE

_____

EXPIRATION

This authorization expires **(insert date)**_____(6 months if not specified)

MY RIGHTS: I may refuse to sign this authorization. My refusal will not affect my ability to receive treatment or eligibility for benefits. I may inspect or obtain a copy of the information for which I am being asked to allow the use or disclosure. I may revoke this authorization at any time, except where as disclosure has already been made in reliance on my prior authorization, but I must do so in writing and submit it to the following address: **Frances Wren MD; 550 Hamilton Ave, Suite 305; Palo Alto, CA 94301.** I have a right to receive a copy of this authorization.

SIGNATURE:

Signature:_____(**Circle one**: patient/ parent or legal guardian)

Date:_____Time:_____

If signed by someone other than patient, state your legal relationship to the patient:

_____

Witness:_____