Authorization to Release Information

Nicodemus M. Watts, MD

Federal law requires your specific authorization for release to appropriate parties any information about your treatment for certain conditions. Please check and sign all pertinent statements below giving your permission to communicate with the following individual, agency, or organization on your behalf:

Patient Name: _____ DOB: _____

I hereby authorize: Nicodemus M. Watts, MD
12625 High Bluff Drive, Suite 111
San Diego, CA 92130-2053
Phone: (858) 598-5207
Fax: (858) 598-5089

To: ☐ Disclose ☐ Obtain ☐ Fax ☐ E-mail

From the following individual, agency, school or organization:

_____
Individual, Agency, or Organization to be contacted

_____
Address City State Zip code

_____ _____ _____
Phone Fax E-mail

The following information:

- ☐ History & background
- ☐ Summary report
- ☐ Service/treatment plan
- ☐ Psychosocial evaluation
- ☐ Psychological evaluation/testing
- ☐ Psychiatric evaluation
- ☐ Consultation report
- ☐ Laboratory work and Test results
- ☐ Other (specify) _____

The information is required for:

- ☐ Diagnostic assessment
- ☐ coordination/collaboration of client's care
- ☐ planning services
- ☐ planning treatment
- ☐ Other (specify) _____

I understand that I may revoke this consent at any time by providing written notice. After one year this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information.

_____ _____ _____
Signature of Patient Printed Name of Patient Date

Relationship to the client: ☐ Self ☐ Person legally authorized to act on behalf of the client