Authorization to Release Information

Nicodemus M. Watts, MD

Federal law requires your specific authorization for release to appropriate parties any information about your or your child's treatment for certain conditions. Please check and sign all pertinent statements below giving your permission to communicate with the following individual, agency, school or organization on your or your child's 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, School 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
- ☐ Other (specify) _____
- ☐ Psychological evaluation/testing
- ☐ Psychiatric evaluation
- ☐ Consultation report
- ☐ Laboratory work and Test results

The information is required for:

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

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 guardian/parent Printed name of guardian/parent Date

_____ _____ _____

Signature of guardian/parent Printed name of guardian/parent Date

Relationship to the patient: ☐ Parent of minor ☐ Guardian
☐ Person legally authorized to act on behalf of the patient