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
3760 Convoy Street, Suite 113
San Diego, CA 92111-3743

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