TIMOTHY A. MURPHY, MD
Psychiatry

AUTHORIZATION FOR RELEASE OR SHARING OF MEDICAL INFORMATION

This authorization is for the use or disclosure of health information pertaining to:

Patient's Name: _____

Social Security# _____ *Date of Birth:* _____

I hereby authorize:

____ ***Dr. Timothy Murphy*** to release my medical and mental health information ***to the Person or Organization below:***

____ ***The Person or Organization*** below to release my medical and mental health information ***to Dr. Timothy Murphy at:*** **577 East Elder St., Ste. C, Fallbrook, CA 92028, Phone: 760-723-5459, Fax: 760-723-7872**

Name of Person or Organization Receiving and/or Releasing Information:

_____
Name

_____ _____
Street Address *City, State and Zip*

_____ _____
Phone *Fax*

Information to be released will include mental health, general health and drug/alcohol use information. Disclosure is specifically requested for:

___ Treatment Summary ___ All Medical Records ___ Labs ___ Psychological Testing

___ Psychological Testing ___ Exchange of Info by Phone ___ Other (specify): _____

Purpose: Records are being released for the following purpose:

___ Ongoing Care ___ Insurance Application ___ Personal Use

___ Disability or Workers Compensation Claim ___ Other (specify) _____

My Rights: I understand that this authorization is voluntary, and that I may refuse to sign without affecting my eligibility for treatment. I may revoke this authorization at any time, provided that I do so in writing, except for information already disclosed. I understand that I may receive a copy of this authorization, and that I may review information that is to be disclosed. The recipient may not lawfully further disclose my health information unless another authorization is obtained from me, or unless the use or disclosure is specifically permitted by law.

Expiration of Authorization: Unless otherwise revoked, this Authorization will expire on _____ (insert applicable date). If no date is indicated, this Authorization will expire 12 months after the date of signing below.

Signature of Patient: _____ _____
(required for ages 12 through adult) Date

Signature of Parent / Legal Guardian: _____ _____
(required for all patients under the age of 18) Date

A photocopy or facsimile of this authorization may be accepted in lieu of the original.