LEAD Behavioral Health

Authorization to Obtain Protected Health Information (PHI)

Patient Name: _____ Date of Birth: _____

I hereby authorize the use or disclosure of PHI on the above named individual which may contain medical, mental health, or substance abuse history and treatment information.

Name of organization or individual authorized to disclose the information:

Name: _____

Address: _____

_____

The information supplied is to be restricted to:

- ☐ Diagnosis
- ☐ Medical Record
- ☐ History & Physical
- ☐ Lab Work
- ☐ Progress Notes
- ☐ Assessment
- ☐ Other: _____

Name of organization or individual authorized to receive and use the information:
Requesting Psychiatrist or Clinician:

- ☐ Virginia Johnson, Ed.D
- ☐ Xavier Lara, MD
- ☐ Indira Adapa, MD
- ☐ Soo Chun, MD
- ☐ Lori Williams, PhD

MAIL TO: 516 W. Shaw, Ste. 200, Fresno, CA 93704

A photographic copy of this authorization shall be valid as the original. This authorization will expire on:

_____.

If I do not specify an expiration date or event, this authorization will expire in six months of the following date:

_____.

Signature: _____ Printed Name: _____

Address: _____ Phone: _____

Revised: February 2011