## CHILD AND FAMILY PSYCHIATRIC CENTER

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## **AUTHORIZATION TO USE/DISCLOSE MENTAL HEALTH INFORMATION**

I authorize:   DR. CALLANA	AN 🗆 JAK	E MAHON, Ph	D, BCBA-D	☐ HECTOR ALEMAN	, LCSW
□ W. DEVIN SMITH, PM	HNP □ JUL	IE NEWMAN	PMHNP [	□JACK OPGENORTH, L	CSW
of Child and Family Psychiatric information described below re	c Center to use garding:	/disclose and fu	ırnish/receive	a copy of my specific Mer	ital Health
Patient Name		Date of Birth			
Consisting of: (initial all that a	Verbal	Med	ications	Billing	
Other (specify)					
to/from					
(Name of Recip	pient)	(Pho	ne)	(FAX)	
(Address)	····				
for the purpose of :   Continuation of Treatment   Other (specify)					
-	PATIENT	RIGHTS A	ND PRIVA	CY	
I understand the writing and except in reliance to the This Authorizate revoked earlier. I have a right to I understand the may be re-disclusubject to private responsibilities information.	at I may revoke the to the extensis Authorization is to remain to a copy of this at protected hereous by the receipt protection I and liabilities	e this Authorizant that CFPC had not that CFPC had not not effect through Authorization. Authorization alth information cipient(s) to oth aws. I also here that may arise the notes of the	ation, at any times already used ughout the during disclosed pure release CF from the release	order to receive treatment me, provided I do so in d or disclosed the informat ration of my treatment, unl rsuant to this authorization or organizations that are n PC from all legal se of such protected health	ion ess ot
By signing below, I acknowled	ge that I have r	ead and unders	tand this Auth	orization.	
		OR			
Signature of Patient (14 and	over)	Date		thorized Person	Date
CFPC/2019			Relationsh	ip to Patient	-