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Authorization for Release of Medical Information

As required by the Health Information Portability and Accountability Act of 1996 (HIPPA) and California Law, Dr. Mesirow may not use or disclose your individual health information except as provided in our Notice of Privacy Practices without your authorization. Your completion of this from gives us permission for the uses and disclosures marked below. Please be aware that once your information leaves our office we will no longer be able to protect that information and the recipients of your information may not be legally required to protect your information.

I hereby release Dr. Mesirow and her staff from any/all legal liabilities that may arise from the release of this information to the party listed below. I authorize Dr. Mesirow to obtain or disclose health information for:

_____ DOB: _____

Print patient's full name

You are hereby authorized to release to the physician listed below (check all that apply):

☐ Entire Psychological Records

☐ Psychotherapy Progress Notes

☐ Neuropsychological/Psychological Testing Results

☐ Inpatient Hospitalization Records

☐ Collateral Contact

☐ Only dates of service from _____ to _____

Information is to be sent

☐ TO ☐ FROM:

Tanya Mesirow, Psy.D.
28991 Old Town Front St, Ste 102
Temecula, California 92590 Office: (951) 775-4057
Fax: (951) 308-1515

☐ TO ☐ FROM

_____

_____

_____

A copy of this authorization is as valid as the original. Unless otherwise revoked, this authorization will expire six (6) months from the date signed.

_____ _____ _____

Patient-Printed Name Patient's Signature Date Signed