Tara Yuan, M.D.
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# Authorization to Release Information

I hereby authorize _____

Address:_____

Phone #: _____ Fax #:_____

❒Release or disclose information to Tara Yuan, M.D.

❒Obtain or use information from Tara Yuan, M.D.

Regarding: ❒All psychiatric/psychotherapy records to:

❒Letter to: _____

❒Other _____

Recipient's relationship to the Patient/Client:_____

Regarding: _____ D.O.B: _____
(Patient's Name) (Patient Date of Birth)

Purpose of release (mandatory): _____
This authorization for use or disclosure of medical information, is being authorized by me, giving Tara Yuan, M.D. permission to disclose or request medical/psychiatric records and information obtained in the course of the diagnosis and/or treatment of me or my legal dependent. This disclosure of medical/psychiatric information complies with the terms of the Confidentiality of Medical Information Act of 1981, section 56, et. Seq, California Civil Code. **I understand that the medical records and information to be released may contain information pertaining to psychiatric, drug and/or alcohol related evaluation and/or treatment, and may also contain confidential HIV (AIDS) related information, including educational, psychological and laboratory test results.** I may revoke this authorization at any time, in writing to my provider, except to extent action has been taken in reliance upon this consent. If it is not earlier revoked, this consent shall terminate without express revocation one year from date shown below.

_____ Signed: _____
(Date) (Patient's Signature)

_____
(If signed by other than Patient, indicate relationship)