CONSENT FOR RELEASE OF INFORMATION

I, _____,
PRINT NAME

HEREBY AUTHORIZE_____
NAME OF HEALTHCARE PROVIDER

AT _____
ADDRESS OF ABOVE PROVIDER

___(_____)_____(_____)_____
PHONE # FAX#

TO RELEASE ALL INFORMATION PERTAINING TO EVALUATION AND

TREATMENT OF MY PSYCHIATRIC AND/OR MEDICAL CONDITIONS

TO: **Harish Kavirajan, MD**
950 South Coast Drive, Ste 202
Costa Mesa, CA 92626
Telephone: (949) 422-6814
Fax: (714) 424-0012

I UNDERSTAND THAT THE PURPOSE OF THIS SHARING OF INFORMATION IS TO FACILITATE CONTINUITY AND COORDINATION OF CARE.

THIS CONSENT FOR INFORMATION SHARING SHALL BE VALID FOR 1 YEAR FROM THE SIGNING OF THIS FORM.

_____

SIGNATURE **DATE**