CONSENT FOR RELEASE OF INFORMATION

I, _____,
PRINT NAME

HEREBY AUTHORIZE: Harish Kavirajan, MD
6 Venture, Suite 125
Irvine, CA 92618
Tel: (949) 422-6814
Fax: (949) 223-4792

TO RELEASE ALL INFORMATION PERTAINING TO EVALUATION AND TREATMENT OF MY PSYCHIATRIC CONDITION(S) TO:

_____
NAME OF DESIGNATED RECIPIENT OF ABOVE INFORMATION

AT _____
ADDRESS OF RECIPIENT

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

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 UNTIL THIS PERMISSION IS REVOKED BY THE UNDERSIGNED

_____
SIGNATURE **DATE**

I AM HEREBY ALSO PROVIDING CONSENT FOR _____ TO EXCHANGE PERTINENT INFORMATION ABOUT MY MENTAL AND PHYSICAL HEALTH WITH DR. KAVIRAJAN. THIS CONSENT SHALL ALSO REMAIN IN EFFECT UNTIL REVOKED BY THE UNDERSIGNED.

_____
SIGNATURE **DATE**