MOHANDESSI PSYCH, LLC
1314 NW Irving Street, suite 508
Portland, Oregon 97209
Phone: (503) 468-8500 Fax: (503) 517-8841

AUTHORIZATION TO OBTAIN MEDICAL INFORMATION

TO: NAME _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____

REGARDING: PATIENT'S NAME: _____
DATE OF BIRTH: _____
SOCIAL SECURITY #: _____

I hereby give full permission for the above individual or organization to disclose the below listed medical information to Mohandessi Psych, LLC:

- ☐ Consultation/Evaluation Notes
- ☐ Outpatient Psychiatric Notes
- ☐ Inpatient Psychiatric Records
- ☐ Medical Notes
- ☐ AIDS/STD Reports
- ☐ Drug/Alcohol Treatment
- ☐ Psychiatric Evaluation
- ☐ Psychological/Social Work Notes
- ☐ Laboratory Test Results
- ☐ Radiology Test Results
- ☐ Employment Records
- ☐ Diagnoses
- ☐ Other _____

By signing, I understand that this authorization, unless specifically limited by me in writing, will extend to all aspects of treatment, as specified above. Further, I understand that this authorization, without prior revocation will expire one year from the date of the signature. (If patient information is to be released to an employer or financial institution, this authorization is valid for only 90 days.)

_____	_____	_____
Signature of Patient or Responsible Person	Relationship to Patient	Date