

MOHANDESSI PSYCH, LLC
1314 NW IRVING STREET, SUITE 508
PORTLAND, OREGON 97209
PHONE: (503) 468-8500 FAX: (503) 517-8841

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

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

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

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

- | | |
|--|--|
| <input type="checkbox"/> Consultation/Evaluation Notes | <input type="checkbox"/> Psychiatric Evaluation |
| <input type="checkbox"/> Outpatient Psychiatric Notes | <input type="checkbox"/> Psychological/Social Work Notes |
| <input type="checkbox"/> Inpatient Psychiatric Records | <input type="checkbox"/> Laboratory Test Results |
| <input type="checkbox"/> Medical Notes | <input type="checkbox"/> Radiology Test Results |
| <input type="checkbox"/> AIDS/STD Reports | <input type="checkbox"/> Employment Records |
| <input type="checkbox"/> Drug/Alcohol Treatment | <input type="checkbox"/> Diagnoses |
| <input type="checkbox"/> 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. I accept that Mohandessi Psych, LLC cannot control how the recipient uses or shares the information once it has been disclosed to the recipient, and laws protecting its confidentiality may or may not protect this information. 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