Eric Levander, M.D., M.P.H.

ASSISTANT CLINICAL PROFESSOR, DAVID GEFFEN SCHOOL OF MEDICINE AT UCLA
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Psychopharmacology and Psychotherapy

AUTHORIZATION TO RELEASE MY HEALTH INFORMATION TO DR. LEVANDER

Name: _____ Date of birth:_____

I. My Authorization

The following provider may disclose my psychiatric and/or general health information to Eric Levander, M.D.:

This authorization ends: ☐ on (date) _____

☐ when the following event occurs_____

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). I may revoke this authorization at any time, provided that I do so in writing and submit it to the above provider. If I did, it would not affect any actions already taken by the above provider.

_____

Patient or legally authorized individual signature Date

_____

Printed Name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative, etc.)

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