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

ASSISTANT CLINICAL PROFESSOR, DAVID GEFFEN SCHOOL OF MEDICINE AT UCLA
DIPLOMATE, AMERICAN BOARD OF PSYCHIATRY AND NEUROLOGY

Psychopharmacology and Psychotherapy

AUTHORIZATION TO RELEASE MY HEALTH INFORMATION

Name: _____ Date of birth:_____

I. My Authorization

Eric Levander may use or disclose the following health care information (check all that apply):

- ☐ All of my psychiatric health information maintained by Eric Levander, M.D., M.P.H.
- ☐ Drug/Alcohol Abuse Treatment:_____
- ☐ Other:_____

Eric Levander may disclose this health information to:

Name/Organization_____

Address: _____

Reason(s) for this authorization (initial):

at my request

other (specify) _____

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 Eric Levander, M.D., M.P.H. If I did, it would not affect any actions already taken By Eric Levander, M.D., M.P.H. based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it. I release Eric Levander, MD, as well as his employees and agents from any liability arising from the release of this information or records.

_____

Patient or legally authorized individual signature Date

_____

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