ROSEVILLE PSYCHIATRY

508 GIBSON DRIVE, SUITE 270A
Roseville, Ca 95678
Phone (916) 771-4747 Fax (916) 771-4745

RELEASE OF INFORMATION

I hereby authorize: AMITA UPADHYAY, M.D.

To: — Release information to: Name: _____

— Obtain information from:

Address: _____

— Exchange information with:

Phone/Fax: _____

The information requested or authorized for release or exchange pertains to (initial all that apply):

— All Mental Health records
— All Medical Health records/ Consultations
— Inpatient/ IOP/ PHP/ Residential mental health records
— Labs/ Genetic testing/ Psychological testing results
— School records/ IEP/ 504 plans
— Pregnancy test results/ Abortion
— HIV/AIDS/ Sexually transmitted diseases
— Alcohol / drug treatment records

This authorization is valid for 5 years from the date below. I may cancel this authorization by sending a written, signed and dated request to the doctor above indicating my desire to cancel. I understand that once my information has been released, the recipient might re-disclose it, my doctor has no control over it and privacy laws may no longer protect it. The purpose of this authorization is to improve the quality of my mental health evaluation or treatment.

_____ _____
Patients Name Date of Birth

_____ _____
Patients Signature Date

_____ _____
Guardian's Signature (if patient is a minor) Date