**Consent to Release Psychiatric, Medical, and/or Alcohol and Drug Abuse Records**
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To: _____ _____
Phone_____ Fax_____
Address _____ _____

I, _____, hereby authorize the physician, psychologist, healthcare facility or other entity named above to disclose, exchange and release healthcare information and records with Adam Strassberg, M.D.

I, _____, hereby authorize Adam Strassberg, M.D. to disclose, exchange and release healthcare information and records to the physician, psychologist, healthcare facility or other entity named above.

1. Reason(s) for this authorization:
□ at my request
□ for evaluation and treatment by Adam Strassberg, M.D.
□ other (specify)_____

2. Disclosure, exchange and release of healthcare information and records shall be limited to the following specific types of information:
□ All health information (including psychiatric) maintained by Dr. Strassberg and by _____ _____
□ My health information relating to the following treatment or condition:_____
□ My health information for the following date(s):_____
□ HIV/AIDS and sexually-transmitted disease information
□ Drug and alcohol abuse treatment information
□ Lab and EKG results, specifically:_____
□ Other: _____

DATE:_____ PATIENT SIGNATURE:_____

Healthcare Information and Records for:
Patient name: _____ _____ DOB:_____
Address _ _____ _____
Phone_____
(Previous name(s): _____)

**Consent to Release Psychiatric, Medical, and/or Alcohol and Drug Abuse Records**
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3. This authorization ends:
□ on (date) _____
□ when the following event occurs_____
□ when specifically revoked in writing.

4. This authorization may be revoked by me at any time, through delivery of written notice to all parties. I have been informed that such revocation might not affect any actions already taken based upon this authorization. I have been informed that I may be unable to revoke this authorization if its purpose was to obtain insurance. I have been informed that once healthcare information is disclosed, the person or organization that receives it may re-disclose it and that privacy laws may no longer protect it.

5. I have been informed that I have the right to ask for and receive a copy of this authorization. I agree that a photocopy or scan of this signed authorization will be as valid as the original.

DATE:_____ PATIENT SIGNATURE:_____

Healthcare Information and Records for:
Patient name: _____ _____ DOB:_____
Address _ _____ _____
Phone_____
(Previous name(s): _____)

As authorized and delimited above, please disclose, exchange, and release all healthcare information and records to Adam Strassberg, M.D. at:

**Mailing Address:** Adam Strassberg, M.D., P.O. Box 60338, Palo Alto, CA 94306-0338

**Office Address:** Adam Strassberg, 415 Cambridge Avenue, #7, Palo Alto, California 94306

**Contact Information:**
Office: 650-427-0779
Mobile: 650-776-9625
Fax: 888-959-7897
Web: www.doctorstrassberg.com
E-Mail: dr.strassberg@gmail.com