Child & Adult Psychiatrists of the Peninsula

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REQUEST FOR TRANSFER OF MENTAL HEALTH RECORDS

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA) and California Law, this practice may not use or disclose your individually identifiable health information except as provided in our Notice of Privacy Practices without your authorization. Your completion of this form means that you are giving permission for the transfer of your mental health information described below. Please review and complete this form carefully.

I HEREBY AUTHORIZE _____, M.D. TO TRANSFER MENTAL HEALTH INFORMATION REGARDING _____ WHOSE DATE OF BIRTH IS _____
(NAME OF CLIENT)

TO

Name _____
Address_____

Phone ( ) _____ Fax ( ) _____

RECORDS TO BE TRANSFERRED:

[ ] ALL RECORDS OR [ ] THE PORTION OF RECORDS CONCERNING _____

SIGNATURE OF CLIENT _____ DATE _____

PRINT NAME _____

IF CLIENT IS A MINOR OR UNDER CONSERVATORSHIP:
SIGNATURE OF PARENT/LEGAL GUARDIAN _____

PRINT NAME (PARENT/LEGAL GUARDIAN) _____

RELATIONSHIP TO CLIENT _____

DATE _____