Pacific Mental Health Services

Release of Information / Records Request

LICENSED TELEHEALTH · ALL 58 CA COUNTIES
(925) 771-0430 · WWW.PACMHS.COM

Complete this form and submit it through your **SimplePractice patient portal** or email it to your clinician. Under HIPAA we respond within 30 days. Psychotherapy process notes carry heightened protections and require a separate specific authorization.

1 · PATIENT INFORMATION

Patient Full Name

Date of Birth

Phone

Email

2 · AUTHORIZATION

I authorize Pacific Mental Health Services to:

☐ Release records to ☐ Obtain records from ☐ Provide records to me directly

Name of Person / Organization

Phone / Fax / Email

Address

3 · INFORMATION TO BE DISCLOSED

☐ Progress notes
☐ Billing records
☐ Treatment summary
☐ Intake / assessment
☐ Diagnosis & treatment plan
☐ Other (specify below)

Purpose of Disclosure (e.g. continuity of care, personal use, legal)

Authorization Expires (date or event)

I understand I may revoke this authorization in writing at any time, except to the extent action has already been taken. Treatment is not conditioned on signing this form. Information disclosed may be subject to re-disclosure by the recipient and no longer protected under HIPAA. Records are protected under HIPAA and California's Confidentiality of Medical Information Act (CMIA).

4 · SIGNATURE

Patient Signature (parent/guardian if under 18)

Date