Sister League
OF SAN DIEGO

RELEASE OF INFORMATION

Patient Name_____ Date of Birth _____
Address _____ City _____ State _____ Zip _____
Phone _____

I ,_____ , authorize Sister League of San Diego, Inc. to obtain information from my mental health record, which may include information about psychiatric diagnosis and treatment and substance abuse issues from:
Name of Facility _____
Address _____ City _____ State _____ Zip _____
Phone _____ Fax _____
Dates of Treatment _____
Information to be released (All mental health records dating back for two years) _____
_____
Purpose of Disclosure: Admission to Sister League of San Diego

1) I understand that, unless withdrawn, this authorization will expire one year from the date of signature. A photocopy of this form will be considered as valid as the original.
2) I understand that I may revoke this authorization at any time by notifying Sister League of San Diego, Inc. at the address indicated below, in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.
3) I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected health information, such as substance abuse treatment information and mental health information.
4) I understand that I can request a copy of this form after I sign it.

By signing below, I acknowledge that I have read and understand this authorization.

_____ _____
Patient's Signature/Authorized Person Date

_____ _____
Witness/Requestor of Records Date

Please fax medical records to:
Sister League of San Diego, Inc.
115 Redwood Street
San Diego, CA 92103

Phone (619) 692-1485
Fax (619) 269-1098
Email: Info@SisterLeagueSD.org

Rev 5/22