

The Dr. De Llanos Clinic, Inc.

*Healing the Body, Spirit and Mind
Bringing Quality to Psychiatry Medicine*

ARIEL DE LLANOS, M.D., CEO

32605 Highway 79 S, Ste 219
Temecula, CA 92592

Phone: (951) 506-9112
Fax: (951) 506-9113

www.DrDeLlanosClinic.com

I, _____, hereby consent to the request of authorization for exchange of confidential medical, or other pertinent information pertaining to my health and mental status.

Patient Information:

Date of Birth: _____ / _____ /19 _____ SS#: _____

Information released to / requested from:

- Ariel De Llanos, M.D.
- Joselee Sarmiento, N.P.
- Deborah Ellis, NP
- Jim Jacobsen, MA, MFT
- Donna Wylie, MA, MFT
- Mark Verdugo, CCDC, CCPS
- _____
(Insert name of Primary Care Provider, Therapist, Family Member, etc.)

Address of Primary Care Provider, Therapist, Family Member, etc. City State Zip

Phone Fax

Information requested:

- Psychiatric Evaluation
- Progress Notes
- Medications
- Psychological test results
- Consultation Reports
- Other
- History and Physical
- Medical Notes
- Record of Attendance
- Treatment Plan
- Oral & Written Communication
- Labs/Xrays
- Discharge Summary
- Diagnosis

Explain: _____

The Dr. De Llanos Clinic, Inc.
Ariel De Llanos, M.D., President
32605 Highway 79 South, Suite 219
Temecula, CA 92592
Ph: 951-506-9112
Fx: 951-506-9113
Em: info@DrDeLlanosClinic.com

Provider Requesting Information:

- Ariel De Llanos, M.D.
- Joselee Sarmiento, N.P.
- Deborah Ellis, N.P.
- Jim Jacobsen, MA, MFT
- Donna Wylie, MA, MFT
- Mark Verdugo, CCDC, CCPS

Patient Signature Date

Parent or Legal Guardian Witness

I understand that confidentiality of records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPPA"). 45 CFR pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided in the regulations. I also understand that I may revoke this consent in writing at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically in one year. I also realize that this is a voluntary consent and I must willingly and knowingly sign this authorization before any records can be released. I may refuse to sign, but in that event the records cannot and will not be released/exchanged. I realize the quality of my care may be affected by failure to secure these records.

A COPY OF THIS AUTHORIZATION IS DEEMED AS VALID AS THE ORIGINAL.