Hope W. Levin, M.D.
310-494-0108

Authorization to Release Information

I, ________________________________, hereby authorize Hope W. Levin, M.D. to
NAME OF PATIENT

exchange information with and/or release copies of my psychiatric and medical information/record(s) pertaining to my treatment to

____
NAME OF PERSON OR TITLE OF ORGANIZATION

____
ADDRESS AND/OR PHONE NUMBER

The relevant and timely information that may be released is limited to:

- ☐ Initial Clinical Summary
- ☐ Verbal Telephone Contact
- ☐ Progress Notes
- ☐ Medication
- ☐ Laboratory Results
- ☐ Consultations
- ☐ Psychological Testing
- ☐ Other ____________________________

These records are required for the purpose of continuity of clinical care. This release will expire one year from the date signed unless otherwise noted.

I certify that I have read this form and that I understand its contents.

____ ________________________
SIGNATURE OF PATIENT 18 YEARS OF AGE OR OLDER DATE

______________________________________ ______________ ______________
SIGNATURE OF PERSON AUTHORIZED IN LIEU OF PATIENT RELATIONSHIP DATE