Laguna Family HEALTH CENTER

32392 S. Coast Hwy, Ste. 250
Laguna Beach, CA 92651
(949) 499-2265

PATIENT INFORMATION

DATE	DOB
/ /	/ /

Patient Name Last	First	Middle Initial	Gender	Marital Status	Age

Home Address	City	State	Zip Code	Home Telephone

Employer/School	Employer/School Address	Work Telephone

Occupation	Social Security Number	Driver's License # / State	Cell Phone

Preferred Phone Number : ☐ Cell ☐ Home ☐ Work	Consent to Leave a Voice Message? ☐ Yes ☐ No	Consent to Leave Confidential Info? ☐ Yes ☐ No
Preferred Email Address:	Consent for Staff/Clinicians to Email You? ☐ Yes ☐ No	**Preferred Pharmacy** (Name & Phone Number):

Address of Financially Responsible Person (Where to send billing statements)	Home Telephone	Work Telephone

Health Insurance Co. Name	Name of Policy Holder	Policy Holder's Relationship to Patient ☐ Self ☐ Spouse ☐ Parent ☐ Other

Insurance Co. Phone Number (back of card)	ID/Policy Number	Group Number	Copay/Deductible	Effective Date
				/ /

Referred By: ☐ Friend/Family ☐ Insurance ☐ Therapist ☐ Primary Care ☐ ER/Hospital ☐ School ☐ Laguna Psych Website ☐ Psychology Today ☐ Internet Search ☐ Yelp ☐ Other_____	Name of Referral Source (if applicable)

COLLABORATION OF CARE AGREEMENT

Name of Primary Care MD/NP:	City: Phone Number:	Consent to Collaborate on Care? ☐ Yes ☐ No
Name of Current Therapist (if applicable):	City: Phone Number:	Consent to Collaborate on Care? ☐ Yes ☐ No
Name of Current Psychiatrist/Psych NP (if applicable):	City: Phone Number:	Consent to Collaborate on Care? ☐ Yes ☐ No

Name(s) of Additional Specialists/Healthcare Professionals you would like us to collaborate with in your health care (if applicable):

Patient / Guardian Signature *Date*

LATE CANCEL & NO-SHOW OFFICE POLICY: 24 BUSINESS HOURS

It is our goal to provide services to you in the most comfortable and timely manner as possible. In order to achieve this we must require you to be on time for your appointments. Our clinicians will make every effort to also be on time, however *due to the nature of the practice and acuity of patient issues / symptoms, clinicians may run late on occasion.*

Once your appointment is scheduled, you will be expected to pay for it unless you provide at least **24 business hours** advance notice of cancellation. *Business hours* are considered the weekdays between Monday and Friday. This means that if you have an appointment on Monday at 4 pm, you must cancel by Friday at 4 pm to avoid being charged. Please note, insurance companies will not reimburse for missed or late cancel sessions nor can they be billed. As a reminder, **credit card(s) on file will be charged for any of these fees**, as consented below.

If you do not provide at least 24 business hours notice, or fail to show for a scheduled appointment, you will be responsible for the **FULL** cost of the session. **Fees range from $150-$195 for medication follow-ups to $150-$225 for 60 min therapy sessions.** A list of office visit fees can be requested. Many practices overbook on purpose so that no-shows and cancellations won't limit access for other patients as well as cause a financial hardship for the practice. Our practice chooses not to do this common practice as we prefer to focus on individualized care that is not rushed or expedited. We pride ourselves on offering care that is outside of the norm of managed health care and that allows each client the time needed to address their specific needs. Because of the focus of our practice and shortage of mental health providers, many of our clinicians have waiting lists and thus, no-shows or late cancels can take away from other clients seeking treatment. We understand that certain emergencies can arise that is beyond your control. Please discuss any concerns with our staff in these circumstances.

I have read and understand the above-mentioned policies and will abide by these for services at Laguna Psych, Inc.

_____

Patient / Guardian Signature *Date*

CREDIT CARD AUTHORIZATION & POLICY

It is our office policy to collect credit card information from all patients or their responsible parties and to maintain this information on file in a HIPAA compliant and confidential manner. We maintain this information for three purposes:
1) We require that **insurance co-payments/fees be paid at the time of your visit.** If a patient is not able to pay their co-payment or fees at the time of the visit with cash or check, we will have their credit card information on file and will process the payment for them. It is too costly for our practice to bill a patient for their co-payment/fees.
2) If an appointment is **cancelled in less than 24 business hours or a patient no shows for a scheduled appointment**, the full fee is due and will be charged to the card on file. No-shows and late cancels cannot be billed to insurance.
3) If a patient becomes **60+ days overdue, with any balance**, we will process the payment using the credit card information or they may set up a monthly installment plan as agreed on by office administration.

Laguna Psych, Inc. does not accept patients without a valid credit card on file.

I, _____,am authorizing Laguna Family Health Center to charge my credit card for the reasons stated above. Furthermore, for outstanding payments equal to or greater than 60 days, I authorize Laguna Family Health Center to charge my credit card for the full amount due. I am aware that my card will be manually entered and thus no signature obtained but I am consenting to this per the above parameters. I will not dispute charges for sessions I have received or that I have not cancelled less than 24 business hours in advance. If I chose to dispute a charge to my credit card company, a copy of this credit card authorization will be provided.

Card Type (circle one): Visa MasterCard American Express

Name on Card:_____Relationship to Patient (circle one): Self Parent Spouse Other

Card #:_____Expiration Date: _____Security Code:_____

Billing Address (if different then primary): _____

_____

Signature of Cardholder (if different then patient) *Date*

_____

Patient / Guardian Signature *Date*

COMMUNICATION & EMERGENCY CONTACTS

Please list **ALL** the individuals whom you consent may discuss your care with our office: (please note any limitations, if applicable):

1._____ 2._____

Name(s) Phone # Relationship Name(s) Phone # Relationship

3._____ 4._____

Name(s) Phone # Relationship Name(s) Phone # Relationship

IN CASE OF AN EMERGENCY ONLY, please list the individuals whom we may inform:

1._____ 2._____

Name(s) Phone # Relationship Name(s) Phone # Relationship

POLICIES & CONSENT FOR TREATMENT OF A MINOR (IF APPLICABLE)

OVERVIEW OF THERAPY WITH KIDS/TEENS: Confidentiality in working with kids/teens can be difficult for parents/guardians to understand. Children/teens won't feel safe to open up in therapy unless they can be assured that what they say will be kept private. On the other hand, as a parent, you have a right to know how your child is progressing. In general, we will tell children that while we will be speaking with their parents from time to time, we won't share specifics of our work unless the child and clinician(s) have agreed beforehand. The exception is when information is obtained that falls under mandated reporter status (child/dependent/elder abuse) and/or knowledge that the child is suicidal or involved in any dangerous activities. In these cases, parents and the appropriate agencies (for abuse) will be notified. *In working with kids/teens in therapy, the therapist/child/family are partners in the growth, but the therapist must serve as the guide while in treatment.* The frequency of parent meetings depends on the individual and is done periodically or as issues arise. In between sessions, *you are welcome to email any concerns or updates to our clinicians* with respect to the time it takes outside of the office to read these concerns/requests. Please use this mode of communication, including phone contact, to convey only the most important information and of course for any urgent issues.

OVERVIEW OF MEDICATION MANAGEMENT WITH KIDS/TEENS: Seeking psychiatric consultation can be an emotional and overwhelming process for parents. There is much to navigate when deciding whether medications are right for your child. Our nurse practitioners are very conservative with medications and will discuss all alternative treatments, the role of therapy, diet/exercise/sleep needs, medical issues, etc. as part of a treatment plan. However, for many, medications are an essential element to treating symptoms and illnesses in mental health, just as in any other area of medicine. There can be a great deal of stigma surrounding mental health, as well as inaccurate information in the media. One area surrounds the accusations of suicide risk in kids/teens on antidepressants, which is based on research that is not methodically sound. In addition, another challenge is that a majority of the medications needed to target certain biochemical pathways and areas of the brain are not FDA approved, but are standard of care when *practicing evidence-based medicine* and psychopharmacology. You can be assured that you will work closely with our NPs and collaborate on a plan that is best for your family.

We/I, the undersigned _____, parent(s) and/or guardian(s) of minor child _____, give you full authority to proceed with a clinical evaluation and treatment as your judgment indicates. This consent is given by me/us as parent/or guardian(s) of said child. We/I have legal power to consent to medical, psychological, and mental health assessment and treatment of said minor child.

_____

Parent/Guardian Signature(s) *Date*

PATIENT HEALTH HISTORY & QUESTIONNAIRE

Current symptoms/reason for seeking treatment:_____

Medical & Psychiatric History

Please list any current or past medical conditions/surgeries:_____

_____

Current Medications (with dosages):_____

_____

Current Vitamins/Herbs/Supplements:_____

Names of any past psychiatric medications:_____

Current/Recent Therapist:_____

History of Psychiatric Hospitalization(s)?: Yes No Suicide Attempts or Self-Injury?: Yes No

History of Depression?: Yes No Anxiety?: Yes No Eating Disorders?: Yes No Mania/Psychosis?: Yes No

Childhood history of mental health symptoms or academic difficulties?:_____

Last Physical Exam & Labs?:_____Allergies:_____Height/Weight:_____

Avg # hours of sleep/night:_____Avg # hours of exercise/week:_____Balanced/Healthy Diet? Yes No Unsure

Family History

List any family medical history (cancer, diabetes, thyroid, heart, etc):_____

_____

List any family psychiatric or addiction history:_____

Parents & Siblings health status:_____

Social History

Relationship Status:_____Names/Ages of Children (if applicable):_____

Length of current marriage/relationship:_____Any concerns with relationship?:_____

Where did you grow up?_____Do you have a history of abuse/neglect towards you of any kind?: Yes No

Parents & Siblings (names/ages):_____

Please list any recent life changes/stressful events/losses:_____

Substance History

Current alcohol, cigarette and caffeine use amount:_____

Current marijuana use?_____Medical Marijuana Card?:_____Current use of other substances?:_____

Past Substance Use/Treatment Centers?_____

Sober Date (if applicable/in recovery):_____ Interested in treatment for smoking cessation?: Yes No N/A

_____

Patient / Guardian Signature *Date*

OFFICE POLICIES & PROCEDURES

This is an agreement between Laguna Family Health Center and the Patient/Client named on this form.
By signing this agreement, you agree to pay for all services that are received and acknowledge understanding of all policies set forth hereto.

Confidentiality & Reporting: While one of the clinician's primary duties is to protect the patient's privacy and confidentiality, this duty is not absolute or without exceptions. Communications are confidential and generally no information will be released without your consent, except for the following: Laguna Family Health Center clinicians are considered *mandatory reporters* for child abuse and dependent adult / elder abuse. Clinicians may also have charts subpoenaed in legal cases however records may be subject to patient-therapist privilege and patient confidentiality/safety are utmost priority. Confidentiality is primary, however in the case of a threat to self or other harm, we must report.

Medical Records: Both law and the professional standards require that we keep appropriate treatment records. You are entitled to review a copy of the records, unless the clinician believes seeing them would be emotionally damaging, in which case, we will be happy to provide them to an appropriate mental health professional of your choice. We can also prepare an appropriate summary for review. Clinicians may have charts subpoenaed in legal cases however records are usually subject to patient-therapist privilege and will only be released with your consent or a court order. You must make your request in writing. *There is a fee for these copies.*

Emergencies: In the event of a psychiatric emergency, such as acute thoughts of harming oneself or others or a medically dangerous reaction to a medication, our clinicians can be reached through the *urgent numbers specified on our office voicemail.* If you are facing a true clinical emergency such as imminent danger to self or others, please call 911 or go to your local emergency room.

Insurance Policies: You are responsible for any amount that is not covered through insurance and charges rendered at times when your insurance is inactive. *It is the responsibility of the patient to fully check your benefits and coverage before your visit(s*), although our office will assist patients in navigating benefits. If we are contracted with your insurance (in-network provider), we must follow our contract and their requirements. We will bill your insurance as a courtesy and after claims are received, the patient and office will receive an Explanation of Benefits (EOB) that reviews the charges and coverage. Due to the complexity of coding, you may see charges on your EOB for services or additional costs (ie. patient education, consults, etc). The amount due to the office is based only on the primary code billed. Please note as well that if you are choosing to use insurance for your visits, *the insurance carrier may request information such as diagnosis and copies of progress notes.* Many clients chose to not use their insurance for office visits because of this element. Please notify our office if you have any questions regarding this.

Medicare Opt-Out Agreement
Laguna Psych, Inc. & affiliated clinicians do NOT participate in Medicare. By law, Medicare-eligible patients are required to enter into a private contract with Laguna Family Health Center and we deliver medical care on a on a fee-for-service basis, which is not reimbursable by Medicare. By accepting the treatment contract with Laguna Family Health Center you agree that you shall not submit a claim for payment under Medicare for services at our office.

Payments: Unless other arrangements are approved by us in writing, the balance on your account is due and payable at the date it is requested in person or in wring by billing statement, whichever is sooner. Accounts are considered past due and delinquent/subject to reporting to collections if not paid within 60 days. *Any copays, office visit fees, or other costs must be paid at the time of service.* Any copays or deductibles are an insurance requirement and cannot be waived or reduced by our office. Please note there is also a *$35 fee for any returned check.*

Telephone Calls & Emails: We must screen all calls to the clinicians during office hours while they are seeing patients. Calls deemed "non emergent" will be handled by the staff in the order received. If it is necessary to leave a message for the clinicians directly, *calls will be returned within 24-48 hours by either the clinician or staff, as appropriate.* Most of our clinicians have preference for email in terms of communication if it is a question or concern on a specific issue that falls beyond the role of the office staff to address. *Emails will be answered by clinicians directly and are confidential, but please keep in mind the limits of technology security.* Emails may also be used to communicate with office staff and all email addresses can be found on our website: www.lagunafamily.com

Prescription Refills: *Prescription refill request will be handled within 24 hours of receipt during regular business office hours.* Prescription refills will not be handled after regular office hours or on the weekend. Please have your pharmacy fax refill requests to our office rather than calling and requesting refills. Certain medications that are controlled substances require monthly scripts that need to be taken into the pharmacy in person and thus cannot be called in or faxed. *Our clinicians reserve the right to deny refills* or reduce quantity/doses. Patient refills may also be denied if patients have not returned for follow-ups within the time frame agreed at the previous appt and thus a follow-up appt must be made before refills are authorized. *Furthermore, if accounts are past due and payments are not received or a payment plan initiated, clinicians' refills will not be granted.*

Changes in Address/Phone or Insurance: *Please notify us as soon as possible if you have any changes to your home or billing address, phone numbers and insurance coverage.* If we do not have current information this will delay payment and possibly cause you to have unexpected expenses. California insurance laws require claims to be filed no later then 90 days after the date of service and for some companies, the timeframe is 30 days. Please also let us know if there are any concerns about the phone number used for reminder calls by our office. You will be asked to fill out a new information profile completely every year.

Legal Testimony: It is often unforeseen, but legal matters requiring the testimony of a mental health professional can and do arise. Legal testimony can often be damaging to the relationship between a patient and clinician. Because of this, we require that you employ independent forensic services should this type of evaluation be required. *If for any reason, we are subpoenaed on your behalf and required to testify or appear in court, you will be responsible for our court fees, which our office can provide upon request.*

Mission Statement & Practice Values: *Our mission is to provide the highest quality mental health care that promotes empowerment, enhances wellness and strengthens our community.* At Laguna Family Health Center we treat the whole client and strive to incorporate biological aspects, psychological factors and social components, which provides the best chance at recovery and focuses on strengthening skills within each individual. Laguna Psych was founded out of the desire to provide mental health services in a model that focuses on wellness and prevention as much as treatment.

Psychotherapy: Psychotherapy may have benefits such as significant reduction in distress, improved social relationships, resolution of specific problems, and clearer understanding of yourself, your values, and your goals. *For therapy to be most successful, you will have to be able to talk openly and honestly, address any difficulties that arise, and put forth active effort outside our sessions.* Our therapists have expertise in several areas of therapy and will collaborate with clients to create and individualized plan. Some therapy is brief and some requires a longer duration to address symptoms and treatment goals. If you have any questions or uncertainties, please discuss them with your therapist.

Pharmacology/Medications: Medications are often used as adjuncts to psychotherapy. If you are seeing clinicians at Laguna Family Health Center for medication management, we will work together to find the optimal combination of medication (if warranted) and therapy that help to fulfill your personal goals. If a medication is indicated, we will discuss with you the reason for the medication, the likelihood of improving with and without medication, and any reasonable alternative treatments. Further, you will understand the type(s) of medication being recommended; dosage and frequency and any possible side effects. As many conditions have an underlying biological basis, medications can be an important component of treating certain illnesses. A common concern in psychiatry of prescribers seeing patients for quick visits, focusing almost entirely on medications, over-prescribing, not being open to working with therapists, and not educating patients about their condition or needs is not what occurs in our practice. Medications are used in conjunction with therapy as the catalyst for growth, with a focus on prescribing only when needed, reducing the use of substances that can increase addiction, and *customizing a pharmacological plan* specific to the unique needs and symptoms of the individual.

Laboratory Tests & Procedures: As part of your treatment plan, our NPs may recommend certain lab tests/blood work to be ordered to assist in diagnosis and rule out medical causes to symptoms. Our NPs are all dual-licensed in both primary care and psychiatry due to our practice focus on comprehensive care. Certain medications also require routine and periodic blood work. Please make sure to discuss any physical symptoms, past medical history, etc. that may be important in your current situation. *If labs are ordered, it is your responsibility to make sure that lab services are an included benefit in your insurance.*

Referrals/Authorizations: *If your insurance requires a referral or preauthorization, you are responsible for obtaining it.* Failure to do so may result in payment denials from your insurance. Occasionally our clinicians will refer you to another specialist. Recommendations are based on their experience with the specialist but the specialist may/may not be an in-network provider with your insurance carrier. You will need to contact the office and/or your insurance to determine if that provider is covered.

Patient-Provider Arbitration Agreement: Lawsuits are something that no one anticipates and everyone hopes to avoid. The method of resolving disputes by arbitration is one of the fairest systems for both patients and psychotherapists. By signing this office policy contract, you are agreeing that all disputes arising out of or in relation to this agreement to provide services shall first be referred to mediation, before, and as a pre-condition of, the initiation of arbitration. The mediator shall be a neutral third party chosen by agreement with Laguna Family Health Center and patient(s). The cost of such mediation, if any, shall be split equally, unless otherwise agreed upon. In the event that mediation is unsuccessful, any unresolved controversy related to this agreement should be submitted to and settled by binding arbitration in Orange County, CA, in accordance with the rules of the American Arbitration Association which is in effect at the time the demand for arbitration is filed. Arbitration agreements between health care providers and their patients have long been recognized and approved by the California court system. You may call witnesses and present evidence. Each party selects an arbitrator who then selects a third neutral arbitrator. These three arbitrators hear the case. This agreement generally helps to limit the legal costs for both patients and psychotherapists. Our goal of course is to provide care in such a way to avoid any such disputes. Most problems begin with communication and thus *if you have any questions or concerns about your care, please discuss with our office / clinician.*

Children & Pets: Children are very special to all of us and we are always happy to see them but for their safety and the courtesy of other patients we must ask that you keep your children with you at ALL times while in our office. Pets are not allowed in the office building, except animals that are registered therapy pets.

Cell Phones & Smoking / E-Cigarettes: Please refrain from talking on your cell phone and smoking / using electronic cigarettes while in the office or waiting area. This is distracting to others around you and also to the environment that we hope to create within our office. Please be mindful that there are several professional businesses within this office building and thus respect their need for a quiet environment.

Grievance Policy: Communication is an essential element of your healthcare and interpersonal relationships. If at any time you have concerns, please discuss with either your therapist/NP and/or our office manager. If resolve has still not been achieved, you have the right to request a meeting with the owner to discuss your concern

By signing below, I acknowledge that I have read the above office policies and procedures and am consenting to treatment with Laguna Family Health Center and agree to abide by the terms during our professional relationship.

_____

Patient / Guardian Signature ***Date***

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. *This is a **SUMMARY** of your rights and our responsibilities regarding your medical information and its privacy. A full version of this Notice is available in our office, per your request. If you have any questions, please ask our Administrative Team. This notification was last updated on September 23, 2013 and will remain in effect until replaced.*

Who: All clinicians and office staff at Laguna Family Health Center are committed to the privacy of medical information of our clients.

Protected Health Information (PHI): refers to information in your health record that could identify you. It is individually identifiable information about your past, present, or future health or condition, the provision of health care to you, or payment for the health care.

How We May Use and Disclose Your Protected Health Information: In accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the HIPAA Privacy Rule, we are permitted to use and/or disclose your PHI for the purposes of treatment, the payment for services you receive, for health care operations, appointment reminders, treatment alternatives, health-related benefits and services, individuals involved in your care, worker's compensation, public health risks, as required by law, and to avert a serious threat to health of safety. For most uses and/or disclosures of your PHI, you will be asked to grant your permission via a signed Authorization to Release Information.

2013 Omnibus HIPAA Final Rule (Update to HIPAA): New privacy standards were adopted in 2013 to further clarify and protect patients' health information/confidentiality when it is disclosed but also to facilitate the flow of medical information between providers. Please read the following so that you understand your rights as a patient as well of the new rules about patient confidentiality. Feel free to ask about privacy, confidentiality, or psychiatric records. *2013 Updates to previous HIPAA policies include the following:*
*Permission from the patient is no longer required for transfer of psychiatric and medical information between providers as long as only the necessary information is supplied. Collaboration of care agreements signed in the office can help to better specify this.
*Psychotherapy notes are not authorized to be release without patient consent and even if consent is obtained, our office often prefers to complete a treatment summary instead to protect your privacy and also better facilitate care.
*Substance abuse records from alcohol/drug programs are exempt from any disclosure with outpatient permission. If you (or your child) are admitted to a treatment program for substance abuse be sure to sign a release so that we can talk to the providers and obtain a discharge summary and lab data upon discharge. Without this we cannot obtain any information.
*We may have to disclose some psychiatric information when required to do so by law without your consent. This includes mandated reporting of child/elder abuse and cases of legal order or subpoena (see confidentiality in Office Policies.
*National security and public health issues. We may be required to disclose certain information to military authorities or federal health officials if it is required for lawful intelligence, public health safety, or public security.

Patient Rights Regarding Your Protected Health Information (PHI) & Psychiatric Records:
*Right to Inspect and Copy your medical information: all patients have the right to inspect and copy their own protected health information (medical record) on request, except for mental health records, which must be reviewed with a the clinician first. In cases where exposure to the record might be harmful to the patient, the clinician may deny the request. If you request a copy of your psychiatric record, we will generally review the record with you. It is unlikely that there would be information in the chart that a patient should not or could not read, but much of the information in the chart may require explanation.
*Right to Request an Amendment: of information you consider incorrect or incomplete.
*Right to an Accounting of Disclosures: that we have made of medical information about you.
*Right to Request Restrictions: or limitations on the information we use or disclose about you for treatment, payment, or health care.
*Right to Receive Confidential Communications: as specified by you and also by alternate means or locations.
*Right to a Paper Copy of This Notice.

Changes to the Notice: We reserve the right to change this Notice and will post a dated copy of in the office.
Complaints: If you believe your privacy rights have been violated, you may file a complaint with the Office Manager or with the Department of Health and Human Services. You will not be penalized for filling a complaint.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of the summary of Notice of Privacy Practices and am aware of my right to have a full copy of the entire HIPAA policy if desired.

_____

Patient/Guardian Signature *Date*

_____

Witness Signature *Date*

Laguna Family Health Center

32392 S. Coast Hwy, Ste 250
Laguna Beach, Ca. 92651
Phone: 949-499-2265 Fax: 949-499-2276

AUTHORIZATION TO RELEASE INFORMATION

Medical, Psychiatric and Substance Abuse Records

Patient Name: _____Date of Birth:_____Today's Date:_____

Address: _____SS#:_____

City/State/Zip: _____Phone: _____

CHECK ONE or BOTH: [] Please **OBTAIN** information **FROM**: [] Please **SEND** my medical information **TO**:

Name of Individual/Organization	*Address*	*Phone Number*	*Fax Number*	*Relationship to Patient*

Rights & Restrictions: I understand that I may refuse to sign this authorization and that my refusal to sign may not affect my ability to obtain treatment. I may inspect or obtain a copy of this authorization to be used and/or disclosed under this authorization in accordance with organizational policy. Photocopy/Fax may be used as original. I understand I have the right to revoke this authorization in writing at any time or change what information is to be released. My revocation will be effective upon receipt, but will not be effective to the extent that this organization has taken action in reliance upon this authorization.

Under California law, however, a recipient of medical information, whether disclosed pursuant to an authorization or to the discretionary provisions of California Civil Code #56.10(x) may not further disclose that medical information except in accordance with a new authorization or as specifically required or permitted by law.

I, _____(*name of patient/guardian*), hereby authorize **Laguna Family Health Center** to disclose information and records obtained in the course of my diagnosis and treatment, and to receive information about my diagnosis and treatment for the following purpose: to obtain previous medical/psychiatric history, assist in diagnosis and treatment and to coordinate care on an ongoing basis with my other providers.

_____

Patient/Guardian Signature ***Date***

_____

Witness Signature ***Date***