PETER PELLIONISZ, M.D. PH.D.
PSYCHIATRY

CONFIDENTIALITY RELEASE FORM FOR PATIENTS

I, _____ authorize _____
(*Patient's Name*) (*Keeper of Psychiatric Records*)

to release my PSYCHIATRIC medical records solely to:

Peter Pellionisz, M.D. Ph.D.
2995 Woodside Road, Suite 350
Woodside, CA 94062
(*Name and Address of Party to Whom the Records Are to be Released*)

- § This authorization is valid for SIX MONTHS (unless otherwise indicated with initialed changes), beginning from the date of signature noted below.
- § This authorization is strictly for the purpose of Psychiatric Evaluation/ Consultation/ Treatment.
- § You have the right to withdraw or revoke this authorization in writing at any time, except to the extent that release of Protected Health Information has already occurred. Please submit your request in writing to the Keeper of Psychiatric Records.
- § You have a right to receive a copy of this authorization.
- § Your health information that will be released as a result of you signing this authorization could be re-disclosed by the recipient. If this occurs, your re-disclosed health information may no longer be protected by state or federal privacy law.

_____ _____
Patient's or Guardian's Signature for Release of Psychiatric Information. *Date*

_____ _____
Witness's Signature (*not required*) *Date*

2995 WOODSIDE ROAD, SUITE 350
WOODSIDE, CA 94062

PHONE: (650) 200-0674
FAX: (415) 907-9678

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PSYCHIATRY

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