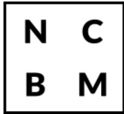
Newport Center For
Behavioral Medicine

1101 Dove Street, Suite 250
Newport Beach, CA 92660

Office: (949) 863-1943
Voicemail: (949) 222-3277
Fax: (949) 863-1029

TAX ID# 27-0128505
CA LIC: G064598
DEA: BS 1860596

CONSENT & AUTHORIZATION TO USE, RECEIVE AND DISCLOSE MENTAL HEALTH INFORMATION

I, ______________________________________, hereby authorize **KENNETH N. SOKOLSKI**
(Patient Name) **(Psychiatrist Name)**

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 increase understanding of my previous history, diagnosis, and treatment; to coordinate care on an ongoing basis with other providers that are also treating me; or to discuss my care with friends or family that may provide support.

Information is to be disclosed to:

Name of Individual / Organization	**Phone Number**	**Address**
•		
•		

I understand that I have the right to revoke this authorization at any time and that cancellation or modification of this authorization must be provided by me in writing and received by NEWPORT CENTER FOR BEHAVIORAL MEDICINE to be effective. I understand that any use or disclosure made prior to the revocation of this authorization will not be affected by the revocation.

I understand that I have the right to refuse consent and signing of this authorization and NEWPORT CENTER FOR BEHAVIORAL MEDICINE shall not condition my treatment upon this refusal. I understand that I am voluntarily signing this form to release my health information to the party or parties designated.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable state laws may protect such information. This authorization is effective immediately and remains in effect for 1 year unless explicitly revoked in writing.

______________________________________ ______________________

Signature of Patient/Parent/Guardian **Date**