Authorization to Release/Exchange Confidential Information

Name * ______________________

Date of Birth * ______________________

E-mail * ______________________

Phone Number * ______________________

I, the undersigned, hereby authorize (Name of Psychiatrist or Pain Practitioner and phone number): *

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I, the undersigned, hereby authorize (Primary Care Provider and Phone number): *

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I, the undersigned, hereby authorize (Name of Psychotherapist and phone number): *

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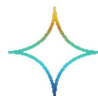
to provide my medical record to and communicate with Soft Reboot Wellness for the purpose of initiating/continuing treatment. I understand that areas of my medical record including information pertaining to mental health, drug and/or alcohol abuse will be included unless I specify that the following areas are not be released:

Release or transfer of the specified information to any person or entity not specified herein is prohibited. This authorization shall be valid for five years, or until it is revoked in writing, or renewed. I understand that I have a right to receive a copy of this authorization upon my request. I release the above parties, Soft Reboot Wellness, and Sara Herman, MD from any and all liability for exchanging this confidential information.

Patient Signature: * ______________________ Date: * ______________________
or Personal Representative's Signature



Alternatively, you may print it and then fax it to us at (650) 419-9877.