anna mccarthy, ph.d.

licensed psychologist (# psy 22684)
1000 Quail Street, Suite 188
Newport Beach, CA 92660

 (949) 544 3040

**Release of Information**

Patient Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Date of Birth: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Date of Authorization**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize Anna McCarthy, PhD. to disclose to, exchange with or request information from the following parties, regarding diagnosis and treatment:

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Telephone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Information authorized to be disclosed, exchanged or requested may include any or all of the following:

[ ]  Drug/Alcohol Treatment Records [ ]  Therapy/Counseling Records

 [ ]  Medical Records [ ]  Psychiatric Evaluations

[ ]  Discharge Summaries [ ]  Telephone communication

[ ]  Psychological Evaluations [ ]  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For the specific purpose of (describe in detail): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Effective dates for this authorization: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ through \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_**

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

**I understand I have the right to:**

1. Refuse to sign this authorization.
2. Receive a copy of this authorization.
3. Restrict what is disclosed with this authorization.

I affirm that everything in this form has been explained to me and I now believe that I understand all of it.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature of Patient or Patient’s Authorized Representative Date

I, (the patient) acknowledge that I received a copy of this completed form: \_\_\_\_\_\_\_\_\_\_ (initial here)

I, (the patient) have declined the copy of this completed form: \_\_\_\_\_\_\_\_ (initial here).

I, Anna McCarthy, PhD., have discussed the issues above with the patient and/or his personal representative. My observations of his or her behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Signature of Professional Printed Name of Professional Date