Larry K. Mortazavi, M.D., CGP
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Release of Information

I hereby authorize Larry Mortazavi, M.D.

To:
- Release information to Name:
- Obtain information from Address:
- Exchange information with Telephone:
- Progress notes • Psychological testing • Psychotherapy notes
- Educational testing • Lab studies • Medical tests/studies
- Other (Bills and statements)

The information requested or authorized for release or exchange pertains to:

- Mental Health • Education • HIV/AIDS • Sexually transmitted diseases
- Drug or alcohol abuse

This authorization is valid for 365 days from the date below or _____, whichever is earlier. I may cancel this authorization by signing, dating, and writing "CANCEL" on this original form or sending a written, signed, and dated request to the doctor above indicating my desire to cancel. I understand that once my information has been released, the recipient might re-disclose it, my doctor has no control over it, and privacy laws may no longer protect it. This authorization aims to improve the quality of my mental health evaluation or treatment.

_____ _____

Patient's Name Date of Birth

_____ _____

Patient's Signature Date

_____ _____

Guardian's Signature (if the patient is a minor) Date