Lidia Zylowska, MD Inc
400 Carlton Ave, Suite 7
Los Gatos, CA 95032
Phone 408 416 4400 / 310 490 2923

AUTHORIZATION FOR RELEASE AND EXCHANGE OF PATIENT INFORMATION

This authorization for use or disclosure of medical information is being requested of you to comply with the terms of the Confidentiality of Medical Information Act of 1981, Civil Code Section 56.104 et seq.

I, _____, Date of Birth ____/_____/_____, hereby authorize the exchange of any and all information and related records regarding my psychiatric evaluation (including alcohol and drug use/ abuse/ or dependence) and treatment between Lidia Zylowska, M.D. to the facility or person(s) named below. This information may be needed for clinical consultation, evaluation, or treatment planning. Use of this authorization form may reveal or imply that mental health services have been/ are being provided. This authorization covers both the release of information presently compiled and information to be complied during the course of my outpatient treatment.

This consent shall become effective _____/_____/_____ and is subject to revocation at any time except to the extent that disclosure has already taken place in reliance on it. If not previously revoked, this consent will terminate in twelve months from the effective date.

_____

_____
Name of Facility or Person(s)

_____
Address

_____
Phone number

_____
Fax number

_____
Patient's Signature Date