

BIO-BEHAVIORAL MEDICAL CLINICS, INC.
Authorization to Obtain Protected Health Information (PHI)

Patient Name: _____ Date of Birth: _____

I hereby authorize the use or disclosure of PHI on the above named individual which may contain medical, mental health, or substance abuse history and treatment information.

Name of organization or individual authorized to disclose the information:

Name: _____

Address: _____

The information supplied is to be restricted to:

- | | | | |
|---|---|---|-----------------------------------|
| <input type="checkbox"/> Diagnosis | <input type="checkbox"/> Medical Record | <input type="checkbox"/> History & Physical | <input type="checkbox"/> Lab Work |
| <input type="checkbox"/> Progress Notes | <input type="checkbox"/> Assessment | <input type="checkbox"/> Other: _____ | |

Name of organization or individual authorized to receive and use the information:

Requesting Psychiatrist or Clinician:

- | | |
|--|---|
| <input type="checkbox"/> Kenneth Steinbach, MD | <input type="checkbox"/> Gina Ayres, LCSW |
| <input type="checkbox"/> Indira D. Adapa, MD | <input type="checkbox"/> James Backlund, LCSW |
| <input type="checkbox"/> Leticia D. Chua, MD | <input type="checkbox"/> David Sommers, LCSW |
| <input type="checkbox"/> H. Dan Smith, MFT | <input type="checkbox"/> Other: _____ |

MAIL TO: 1060 W. Sierra, Suite 105, Fresno, CA 93711 or FAX: 559-437-1118

A photographic copy of this authorization shall be valid as the original. This authorization will expire on:

_____.

If I do not specify an expiration date or event, this authorization will expire in six months of the following date:

_____.

Signature: _____ Printed Name: _____

Address: _____ Phone: _____