**TMS Therapeutics in San Diego, Inc.**

**8851 Center Drive, Suite 200**

**La Mesa, California 91942**

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Authorization to Release, Obtain, and/or Exchange

**Confidential records and Information**

**Patient Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Birth Date**:\_\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_

 (Last) (First)

**Home Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Tel**:(\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Street and Number)

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (City) (State) (Zip)

**I hereby authorize TMS Therapeutics In San Diego, Inc. to release, obtain &/or exchange information with:**

**Person/Institution:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Tel**: (\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_**\_\_\_\_\_\_\_**

**Address**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Fax**:(\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Street and Number)

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (City) (State) (Zip)

Sp**ecific Information to be Released, Obtained, or Exchanged (Check ALL that Apply, “N/A” if Does Not Apply):**

\_\_x\_\_Date of Treatment \_\_x\_\_Medical Records

\_\_x\_\_Treatment Summary \_\_x\_\_Laboratory/Diagnostic Test Results

\_\_x\_\_Educational Assessment/Reports \_\_x\_\_HIV/AIDS Status

\_\_x\_\_Psychological Assessment/Testing Results \_\_x\_\_Drug and Substance Abuse History

\_\_x\_\_Psychiatric and Counseling Records \_\_x\_\_Oral Communication as Needed

**For the Following Purpose(s):** \_\_X\_\_Continuity and/or coordination of care.

*I understand that I can obtain a copy of this authorization. A copy of this form is as valid as the original. I understand that I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released.) This revocation must be delivered in writing TMS Therapeutics In San Diego, Inc. Unless otherwise revoked, this authorization will remain in effect for one year from the date signed. This provider is released from legal responsibility or liability for the release of the above information to the extent authorized and indicated herein.*

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Patient’s Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Signature Date