Arman Danielyan, M.D.

Diplomate, American Board of Psychiatry and Neurology
Child, Adolescent & Adult Psychiatry and Psychopharmacology

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Release of Information

I, _____, hereby authorize Arman Danielyan, MD, to have bilateral exchange of information that is contained in my/my child's medical records with:

Name:_____

Organization: _____

Address: _____

Tel/Fax: _____

Email: _____

under the conditions listed below:

1. This information will be limited to:
   _____Psychiatric/medical/alcohol/drug abuse evaluation.
   _____Psychiatric/medical/alcohol/drug abuse discharge summary.
   _____ Progress notes. _____Psychological testing.
   _____ Psychotherapy notes. _____Educational testing.
   _____ Lab studies. _____Sexually transmitted Disease
   _____ Medical tests/studies. _____HIV/AIDs
   _____ Other _____

2. This consent is subject to revocation at any time except to the extent that action has been taken in reliance thereon. If not previously revoked, this consent will terminate upon 90 days

3. Additional consent must be obtained for any other transfer or disclosure of this information. 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. The purpose of this authorization is to improve the quality of my mental health evaluation or treatment.

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4. I understand that I may receive a copy of this release.

This authorization is valid for 360 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 by sending a written, signed and dated request to the doctor above indicating my desire to cancel.

_____ _____
Patients Name Date of Birth

_____ _____
Signature Date

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

1655 North Main Street, Suite 200, Walnut Creek, California 94596