Ayala Child, Adolescent and Adult Psychiatry, P.C.
1233 Haddonfield Berlin Rd, Suite 4
Voorhees, NJ, 08043
Ph: 800-943-1817 Fax: 856-823-1012
ayalapsychiatry@icloud.com

Omar Ayala MD

AUTHORIZATION TO RELEASE/OBTAIN HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name (if any): _____

I request and authorize Ayala Child and Adolescent Psychiatry, P.C., to release/obtain healthcare information for the patient named above to/from:

Name:_____

Address: _____

City:_____ State: _____ Zip Code: _____

Fax: _____ Phone: _____

Email: _____

Please Check which this request and authorizations applies to:

[] All healthcare information

[] Healthcare information relating to the following treatment, condition or dates:

_____

[] Other: _____

Reason for release:_____

This request is valid until the date of _____or 90 days from date of signature below.

Patient Signature (14 and older):_____Date: _____

Patient Name Printed: _____

Guardian Signature: _____ Date: _____

Guardian Name Printed: _____Relationship to Patient: _____