



Fairhaven Behavioral Health & Wellness
 910 Harris Avenue, Suite 102
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AUTHORIZATION FOR DISCLOSURE OF HEALTHCARE INFORMATION

Patient Name: _____

Address: _____

Date of Birth: _____

Guardian Name: _____

Phone Number: _____

Patient signature (if 13 years or older): _____ Date: _____

By signing the above, I authorize Dr Samardeep Randhawa to
 (Please mark one or both)

- disclose to
- receive from

medical information pertinent to me or my dependent child's care, to the following individuals:

Name: _____ Phone: _____ Fax: _____

Name: _____ Phone: _____ Fax: _____

Name: _____ Phone: _____ Fax: _____

Please initial all information that may be disclosed/received as indicated above:

Verbal communication regarding treatment, care, and diagnosis	
Complete records	
Mental health records	
Labs/Imaging	
Substance use/STD testing	
Scheduling and cancelling appointments	
Requests for medication refills	

I understand that I may refuse to grant the consent for release of any of the above information, and such a refusal will in no way risk my right to continue to obtain treatment, unless disclosure is otherwise permitted by law or necessary for treatment. I understand that I may revoke this Authorization at any time except to the extent that action has been taken. **Parent/Guardian signature is required for all children under the age of 13. For children age 13 and over, we request their signature. I understand that the information being requested above for a minor child may include information regarding myself, the parent/legal guardian, relevant to my child's treatment and condition. I consent to the disclosure of such information.**