JOSIE HOWARD, MD
PSYCHIATRY AND PSYCHODERMATOLOGY
490 Post Street Suite 1703 San Francisco, CA 94102 tel. and fax 415.217.0017

AUTHORIZATION TO RELEASE AND RECEIVE INFORMATION

I, _____
(Patient's Name)

Hereby authorize **Josephine Howard, M.D**. to *release* information or records

To: _____

_____ _____
(Street Address) (Phone)

_____ _____
(City, State, Zip Code) (Fax)

And for **Josephine Howard, M.D**. to *receive* information or records from the person or agency, written in above.

This disclosure is for, but not limited to, the purpose of treatment or evaluation.

The records or information may be released by telephone, fax, or paper copy.

I understand that these records may include psychiatric, alcohol and drug abuse information. The information disclosed may also include records and reports concerning Human Immunodeficiency Virus (HIV).

This authorization may be revoked by me at any time, except to the extent of action already taken. Unless otherwise revoked, this authorization will expire at the end of my treatment with Josie Howard, M.D.

Dr. Howard has offered me a copy of this form for my records.

_____ _____
Patient Signature Date