

# JEFFREY S. GANDIN, M.D.

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## AUTHORIZATION TO RELEASE OUTPATIENT PSYCHOTHERAPY, PSYCHIATRIC, MEDICAL, BILLING AND/OR ALCOHOL-DRUG ABUSE RECORDS AND INFORMATION

I hereby authorize **JEFFREY GANDIN, M.D. 450 N. BEDFORD DR., STE. 307, B.H., CA 90210 (or the covering physician)** to release the information which is contained in any outpatient psychotherapy, psychiatric, medical, billing, alcohol and/or drug abuse records which he may have regarding **ME**, (FULL NAME) \_\_\_\_\_, including any and all information gained in interviewing **ME** and examining **ME** including, but not limited to, any outpatient treatment with a psychotherapist, under the conditions listed below:

1. The information and records which may be released are limited to all medical records or other information obtained by **JEFFREY GANDIN, M.D. (or the covering physician)** through interviews with **ME** or inquiries concerning or obtained from other persons, and will include all outpatient psychotherapy, psychiatric, medical, billing, alcohol and/or drug abuse records which are in the possession or control of **JEFFREY GANDIN, M.D. (or the covering physician)**.
2. The purpose of such disclosure is for use in connection with: **Coordination of care, payment, and/or support** and (if more) \_\_\_\_\_ The information and records released pursuant to this consent will not be used for any other purpose.
3. The persons or entities authorized to receive the information and records covered by this consent are (please include relationship/position, name, address, FAX, Tel #):

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4. I understand that there is a risk that the person receiving information or documents pursuant to this authorization may re-disclose the information and documents in a manner which will no longer provide protection for the information and documents.
  5. I understand that I may refuse to sign this authorization.
  6. I understand that I may receive a copy of this authorization.
  7. I understand that this release automatically expires within 90 days unless I authorize the following expiration by checking the associated box:

- I would like this authorization to expire only once my care at Dr. Gandin's office has terminated.  
 I would like this authorization to expire on the following date: \_\_\_\_\_

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Patient's/Rep Signature

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Patient's/Rep Name (printed)

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Date