ocanxietycenter

AUTHORIZATION FOR EXCHANGE OF INFORMATION

I hereby authorize the Orange County Anxiety Center (OCAC), and its employees, including but not limited to Curtis Hsia, Ph.D., and:

Doctor / Agency

Address

City, State | Zip Code

Phone number | Email

To share with each other any and all information in their possession acquired in the course of evaluation and/or treatment of

Name of patient

In addition, I authorize the OC Anxiety Center to share information with any emergency caregivers who are involved in my care in the event of medical or psychiatric emergency. You may accept a photocopy of this authorization.

Patient signature | Date

Witness signature (if other than patient)

Name of witness

Patient information:

Patient address | SS#

City, State | Zip Code | Date of birth

Patient phone number | Email

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