BEACHES TMS
& BRAIN HEALTH

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AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL INFORMATION

This patient is being evaluated for psychiatric services and the possibility of a treatment resistant mental health diagnosis. In order to determine the appropriate treatment for this patient (possible Transcranial Magnetic Stimulation or Spravato), we need a complete history of prior psychiatric treatment, modalities and outcomes for our mutual patient. You have been identified as an institution or provider that has helped treat this patient for this health condition.

I hereby authorize Dr. Alina Galliano-Pardo, M.D. to exchange, obtain, and/or release all information pertaining to the medical, psychiatric, psychological, and/or educational evaluation and treatment of:

Patient Name (printed) Patient Date of Birth

_____ _____

_____
Name of prescriber/institution releasing/obtaining information to/from

_____
Address

_____
City/State/Zip

_____
Phone Number

_____
Fax Number

A revocation may be signed at any time.
I hereby release Dr. Alina Galliano-Pardo, M.D., from any legal liability which may arise as a result of the use of the released information. This information has been disclosed to you from confidential records. Any further disclosure is strictly prohibited unless the client provides written consent.

_____
Signature of Patient (or legal guardian)

_____
Today's date

_____
Signature of Witness

_____
Today's date