A Mindful Path to Mental Health
Carolina Bonilla Jacome, M.D.

10419 Old Placerville Rd, Ste 252
Sacramento, CA 95827
www.aMindful-Path.com
Ph (916) 536-6030
Fax (916) 244-3865

Mailing Address:
PO Box 1267
Fair Oaks, CA 95628

RELEASE OF INFORMATION

Patient's Name: _____

I hereby authorize Carolina Bonilla Jacome, M.D. to:

- ☐ Release Information to
- ☐ Obtain information from
- ☐ Exchange information with

Outside Provider Name: _____
Phone: _____ Fax: _____
Address: _____
City: _____ State: _____ ZIP Code: _____
email address: _____

The information requested or authorized for release or exchange pertains to (initial all that apply):

_____ Initials — All of my health information (including information pertaining to evaluation and treatment of any physical and/or mental condition)

_____ Initials — All records, including billing and financial records

_____ Initials — My billing and financial records, with no additional health information, outside of what is included in my billing statements and insurance claims

If you wish to release only specific records or types or information, please initial the categories you wish to release:

_____ Initials — Initial Evaluation and Consultation Reports

_____ Initials — Progress Notes

_____ Initials — Diagnosis

_____ Initials — Current medication list

_____ Initials — Lab Results/Genetic Testing

A Mindful Path to Mental Health
Carolina Bonilla Jacome, M.D.

10419 Old Placerville Rd, Ste 252
Sacramento, CA 95827
www.aMindful-Path.com
Ph (916) 536-6030
Fax (916) 244-3865

Mailing Address:
PO Box 1267
Fair Oaks, CA 95628-1267

_____ Initials Medical studies (EKG, EEG, imaging reports, etc)

_____ Initials Information related to HIV/ AIDS/sexually transmitted diseases

_____ Initials Chemical Dependence Treatment Records

_____ Initials Psychological testing and psychometric measures

_____ Initials Other (please specify) _____

This authorization is valid for:

☐ One year from today
or
☐ Other (Please Specify) _____

☐ For the duration of treatment

I may cancel this authorization by sending a written, signed and dated request to the doctor above indicating my desire to cancel. I understand that once my information has been released, the recipient might re-disclose it, my doctor has no control over it and privacy laws may no longer protect it. The purpose of this authorization is to improve the quality of my mental health evaluation or treatment.

_____ Patient's Name

_____ Patient's Date of Birth

_____ Patient or Guardian Signature

_____ Date