Dan Gardner, MD

Psychiatry and Psychoanalysis

Diplomate, American Board of Psychiatry and Neurology

Distinguished Life Fellow, American Psychiatric Association

Del Mar: 12526 High Bluff Drive, Suite 300, San Diego, CA 92130

San Diego: 4550 Kearny Villa Road, Suite 214, San Diego, CA 92123

Phone/fax: 858 560 5609 dgardner@ucsd.edu [www.dangardnermd.com](http://www.dangardnermd.com)

**Registration Information**

|  |
| --- |
| Patient’s Legal Name  |
| LAST       | FIRST        | MIDDLE       |
| Permanent AddressSTREET 13725 | CITY       | STATE       | ZIP       |
| Telephone (include area code)Home       Bus.      Cell:       | Date of Birth Month       Day       Year       | Age       | Male [ ] Female [ ]  |
| Social Security Number      | Email       |  | Single [ ]  Widowed [ ] Married [ ]  Divorced [ ]  |
| Occupation       Spouse        |
| Who is responsible for payment of your medical bill?      | Relationship |
| Permanent AddressStreet       | City       | State       | Zip       |
| Telephone (include area code)Home       Bus.       | Social Security Number       | Occupation      |
| Name of Employer or Responsible Representative      | Employer’s Phone Number |
| Address of Employer      |  |
| Name of Relative or Friend, Not Living With Patient      | Relationship       |
| Address      | Telephone (include area code)Home       | Bus.       |
| Who is to be notified in case of emergency?      | Relationship       |
| Address      | Telephone (include area code)Home       | Bus.       |
| Patient Referred by       Registration Completed by       ALLERGIES INCLUDING MEDICATIONS        |
|  patieNT’S OR AUTHORIZED PERSON’S SIGNATURE  DaTE |

|  |
| --- |
| Dan Gardner, MDPsychiatry and PsychoanalysisDiplomate, American Board of Psychiatry and NeurologyDistinguished Life Fellow, American Psychiatric AssociationDel Mar: 12526 High Bluff Drive, Suite 300, San Diego, CA 92130San Diego: 4550 Kearny Villa Road, Suite 214, San Diego, CA 92123Phone/fax: 858 560 5609 dgardner@ucsd.edu [www.dangardnermd.com](http://www.dangardnermd.com) |
| HEALTH HISTORY QUESTIONNAIRE |
| All information contained in this questionnaire is strictly confidential and will become part of your medical record. |
| Name:      (Last, First, M.I.) | [ ]  M[ ]  F | DOB       |
| Marital Status: [ ]  Single [ ]  Partnered [ ]  Married [ ]  Separated [ ]  Divorced [ ]  Widowed |
| Previous or Referring Doctor:       | Date of Last Physical Exam:       |
| PERSONAL HEALTH HISTORY |
| Childhood Illness:  | [ ]  Measles [ ]  Mumps [ ]  Rubella [ ]  Chicken Pox [ ]  Rheumatic Fever [ ]  Polio |
| Immunizations and Dates: | [ ]  Tetanus       | [ ]  Pneumonia       |
| [ ]  Hepatitis       | [ ]  Chicken Pox       |
| [ ]  Influenza       | [ ]  MMR       |
|  | Measles, Mumps, Rubella |
| List Any Medical Problems That Other Doctors Have Diagnosed: |
|        |
| Surgeries: |
| Year | Reason | Hospital |
|       |       |       |
|       |       |       |
|       |       |       |
|       |       |       |
| Other Hospitalizations: |
| Year | Reason | Hospital |
|       |       |       |
|       |       |       |
|       |       |       |
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|  |  |  |
| Have you ever had a blood transfusion? [ ]  Yes [ ]  No |

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| List Your Prescribed Drugs and Over-the-Counter Drugs, Such as Vitamins and Inhalers: |
| Name of Drug | Strength | Frequency Taken Purpose Side Effects |
|       |       |                   |
|       |       |                   |
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| Allergies: |
| **Name of Drug/Food/Other** | **Reaction You Had** |
|       |       |
|       |       |
|       |       |
| HEALTH HABITS AND PERSONAL SAFETY |
| Exercise: | [ ]  Sedentary (No exercise) [ ]  Mild Exercise (i.e., climb stairs, walk 3 blocks, golf)[ ]  Occasional Vigorous Exercise (i.e., work or recreation less than 4x/week for 30 min.)[ ]  Regular Vigorous Exercise (i.e., work or recreation 4x/week for 30 minutes) |
| Diet: | Are you dieting? [ ]  Yes [ ]  NoIf yes, are you on a physician prescribed medical diet? [ ]  Yes [ ]  No# of meals you eat in an average day?\_\_\_\_\_\_\_\_\_\_\_\_\_\_Rank Salt Intake [ ]  Hi [ ]  Med [ ]  Low Rank Fat Intake [ ]  Hi [ ]  Med [ ]  Low  |
| Caffeine: | [ ]  None [ ]  Coffee [ ]  Tea [ ]  Cola # of Cups/Cans Per Day?       |
| All information contained in this questionnaire will be kept strictly confidential. |
| Alcohol: | Do you drink alcohol? [ ]  Yes [ ]  NoIf yes, what kind?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How many drinks per week? \_\_\_\_\_Are you concerned about the amount you drink? [ ]  Yes [ ]  No Have you considered stopping? [ ]  Yes [ ]  NoHave you ever experienced blackouts? [ ]  Yes [ ]  NoAre you prone to “binge” drinking? [ ]  Yes [ ]  NoDo you drive after drinking? [ ]  Yes [ ]  No |
| Tobacco: | Do you use tobacco? [ ]  Yes [ ]  No[ ]  Cigarettes - Packs/day       [ ]  Chew - #/day       [ ]  Pipe - #/day      [ ]  Cigars - #/day       [ ]  # of Years       [ ]  or Year Quit       |
| Drugs: | Do you currently use recreational or street drugs? [ ]  Yes [ ]  NoHave you ever given yourself street drugs with a needle? [ ]  Yes [ ]  No |

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| All information contained in this questionnaire will be kept strictly confidential. |
| Sex: | Are you sexually active? [ ]  Yes [ ]  NoIf yes, are you trying for a pregnancy? [ ]  Yes [ ]  NoIf not trying for a pregnancy, list contraceptive or barrier method used      Any discomfort with intercourse? [ ]  Yes [ ]  NoIllness related to the Human Immunodeficiency Virus (HIV), such as AIDS, has become a major public health problem. Risk factors for this illness include intravenous drug use and unprotected sexual intercourse. Would you like to speak with your provider about your risk of this illness? [ ]  Yes [ ]  No |
| Personal Safety: | Do you live alone? [ ]  Yes [ ]  NoDo you have frequent falls? [ ]  Yes [ ]  NoDo you have vision or hearing loss? [ ]  Yes [ ]  NoDo you have an Advance Directive and/or Living Will? [ ]  Yes [ ]  NoWould you like information on the preparation of these? [ ]  Yes [ ]  NoPhysical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider? [ ]  Yes [ ]  No |
| FAMILY HEALTH HISTORY |
|  |  | Age | Age at Death | Significant Health Problems or Cause of Death |  | Age | Age at Death | Significant Health Problems or Cause of Death |
| Father |  |       |       |       | Children | [ ]  M[ ]  F |       |       |       |
| Mother |  |       |       |       | [ ]  M[ ]  F |       |       |       |
| Brothers and Sisters | [ ]  M[ ]  F |       |       |       | [ ]  M[ ]  F |       |       |       |
| [ ]  M[ ]  F |       |       |       | [ ]  M[ ]  F |       |       |       |
|  | [ ]  M[ ]  F |       |       |       | Grandparents (Mother’s Side) |
| [ ]  M[ ]  F |       |       |       | *Male* |       |       |       |
| [ ]  M[ ]  F |       |       |       | *Female* |       |       |       |
| [ ]  M[ ]  F |       |       |       | Grandparents (Father’s Side) |
| [ ]  M[ ]  F |       |       |       | *Male* |       |       |       |
| [ ]  M[ ]  F |       |       |       | *Female* |       |       |       |
| FAMILY MENTAL HEALTH HISTORY |
| Has any blood relative had one of the following conditions? Depression, Anxiety, Panic, Schizophrenia, Psychosis, Drug or Alcohol Problems, Phobias, Obsessive Compulsive Disorder, Incarceration, Legal Problems.  |
| **Relative** | **Condition** | **Treatment** |
|       |       |       |
|       |       |       |
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|       |       |       |

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| MENTAL HEALTH |
| Are you experiencing, or have you had in the past, the symptoms/problems below?Stress [ ]  Yes [ ]  NoDepression [ ]  Yes [ ]  NoCrying easily/ frequently [ ]  Yes [ ]  NoAttempted suicide [ ]  Yes [ ]  NoSeriously thought about hurting yourself [ ]  Yes [ ]  NoWishes to die [ ]  Yes [ ]  NoFeelings of hopelessness [ ]  Yes [ ]  NoMood swings [ ]  Yes [ ]  NoSensitive to rejection [ ]  Yes [ ]  NoPeriods of euphoria/excitement/high energy..............................……………. ……………… ..[ ]  Yes [ ]  NoIrritability [ ]  Yes [ ]  NoFrequent sadness [ ]  Yes [ ]  NoTrouble sleeping [ ]  Yes [ ]  NoProblems with eating or your appetite [ ]  Yes [ ]  NoRecent weight change [ ]  Yes [ ]  NoSelf-critical thoughts [ ]  Yes [ ]  NoRestlessness [ ]  Yes [ ]  NoLoss of interest in work [ ]  Yes [ ]  NoTemper outburts [ ]  Yes [ ]  NoLack of purpose or meaning [ ]  Yes [ ]  NoFeelings of regret [ ]  Yes [ ]  No Feelings of guilt [ ]  Yes [ ]  NoFear of dying [ ]  Yes [ ]  NoPanic/anxiety attacks [ ]  Yes [ ]  NoExcessive anxiety [ ]  Yes [ ]  NoWorrying much of the time [ ]  Yes [ ]  NoDisturbing dreams [ ]  Yes [ ]  NoFinancial worries [ ]  Yes [ ]  NoInability to relax [ ]  Yes [ ]  NoDifficulty expressing feelings [ ]  Yes [ ]  NoFeelings of failure [ ]  Yes [ ]  NoDifficulty making decisions [ ]  Yes [ ]  NoTrouble remembering things [ ]  Yes [ ]  NoDifficulty thinking [ ]  Yes [ ]  NoInability to concentrate [ ]  Yes [ ]  NoSuspiciousness of others [ ]  Yes [ ]  NoActing without thinking [ ]  Yes [ ]  NoFeelings of unreality [ ]  Yes [ ]  NoFear of being in public [ ]  Yes [ ]  NoFeel cut off from others [ ]  Yes [ ]  NoConcerns about going crazy [ ]  Yes [ ]  NoJealousy [ ]  Yes [ ]  NoFeelings easily hurt [ ]  Yes [ ]  NoTry to be perfect [ ]  Yes [ ]  NoUnable to please others [ ]  Yes [ ]  NoDivorce [ ]  Yes [ ]  NoBreaking the law [ ]  Yes [ ]  NoLack of friends [ ]  Yes [ ]  NoPersistent lying [ ]  Yes [ ]  NoAvoid being alone [ ]  Yes [ ]  NoSexual problems [ ]  Yes [ ]  NoDistressing sexual feelings/thoughts [ ]  Yes [ ]  NoFrequent short-term relationships [ ]  Yes [ ]  NoWish to hurt others [ ]  Yes [ ]  NoMarital problems [ ]  Yes [ ]  NoGambling [ ]  Yes [ ]  NoCounseling/psychotherapy/psychiatric treatment [ ]  Yes [ ]  No**Past Psychotherapy / Psychiatric Treatment:** Dates Reason Therapist Why Ended |
| WOMEN ONLY |
| Age at onset of menstruation:       Date of last menstruation:      Period every       days. Heavy periods, irregularity, spotting, pain, or discharge? [ ]  Yes [ ]  NoNumber of pregnancies       Number of live births       Are you pregnant or breastfeeding? [ ]  Yes [ ]  NoHave you had a D&C, hysterectomy, or Cesarean section? [ ]  Yes [ ]  NoAny urinary tract, bladder, or kidney infections within the last year? [ ]  Yes [ ]  NoAny blood in your urine? [ ]  Yes [ ]  NoAny problems with control of urination? [ ]  Yes [ ]  NoAny hot flashes or sweating at night? [ ]  Yes [ ]  NoDo you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period? [ ]  Yes [ ]  NoExperienced any recent breast tenderness, lumps, or nipple discharge? [ ]  Yes [ ]  NoDate of last pap smear and rectal exam?       |
| MEN ONLY |
| Do you usually get up to urinate during the night? [ ]  Yes [ ]  No If yes, # of times      Do you feel pain or burning with urination? [ ]  Yes [ ]  NoAny blood in your urine? [ ]  Yes [ ]  NoDo you feel burning discharge from penis? [ ]  Yes [ ]  NoHas the force of your urination decreased? [ ]  Yes [ ]  NoHave you had any kidney, bladder, or prostate infections within the last 12 months? [ ]  Yes [ ]  NoDo you have any problems emptying your bladder completely? [ ]  Yes [ ]  NoAny difficulty with erection or ejaculation? [ ]  Yes [ ]  NoAny testicle pain or swelling? [ ]  Yes [ ]  NoDate of last prostate and rectal exam?       |

**Other Problems**

**Please place an "X" after current problems/symptoms:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **General:** |  | **Nervous System:** |  | **Skin:** |  |
| Appetite Change | [ ]  | Yawning | [ ]  | Rash  | [ ]  |
| Weight Change | [ ]  | Insomnia | [ ]  | Itching  | [ ]  |
| Fatigue | [ ]  | Excessive Sleep | [ ]  | Sweating  | [ ]  |
| Flu-Like Symptoms  | [ ]  | Drowsiness | [ ]  | Dry Mouth  | [ ]  |
| Chills | [ ]  | Headaches | [ ]  | Dry Skin  | [ ]  |
| Fever | [ ]  | Anxiety | [ ]  | Dry Eyes | [ ]  |
| Infection | [ ]  | Nervousness  | [ ]  |  |  |
| Hot Flashes | [ ]  | Restlessness | [ ]  | **Respiratory:** | [ ]  |
| Swelling | [ ]  | Apathy | [ ]  | Breathing Difficulty  | [ ]  |
| Drooling | [ ]  | Nightmares | [ ]  | Apnea  | [ ]  |
| Weakness  | [ ]  | Irritability | [ ]  | Sinusitis  | [ ]  |
| **Vision:** | [ ]  | Anger  | [ ]  | Sore Throat  | [ ]  |
| Blurred Vision  | [ ]  | Impatience | [ ]  | Cough | [ ]  |
| Double Vision  | [ ]  | Confusion | [ ]  |  |  |
| Vision Loss  | [ ]  | Thinking Problem  | [ ]  | **Heart:** | [ ]  |
|  |  | Forgetfulness | [ ]  | Fast/Slow Heart Rate  | [ ]  |
| **Hearing:** |  | Fainting | [ ]  | Palpitations  | [ ]  |
| Hearing Loss  | [ ]  | Dizziness | [ ]  | Chest Pain | [ ]  |
| Ringing in Ears  | [ ]  | Light Headedness | [ ]  |  |  |
| Sinusitis  | [ ]  | Vertigo  | [ ]  | **Digestive Tract:** |  |
|  |  | Balance Problem | [ ]  | Nausea  | [ ]  |
| **Other Senses:**  |  | Tingling  | [ ]  | Indigestion  | [ ]  |
| Abnormal/Absent Taste  | [ ]  | Numbness  | [ ]  | Constipation  | [ ]  |
| Abnormal/Absent Smell  | [ ]  | Abnormal Movements  | [ ]  | Diarrhea  | [ ]  |
|  |  | Tremor  | [ ]  | Vomiting  | [ ]  |
|  |  | Loss of Consciousness  | [ ]  | Abdominal Pain  | [ ]  |
|  |  |  |  | Flatulence | [ ]  |
|  |  |  |  |  |  |
| **Blood:** |  | **Urinary System:** |  | **Reproductive/Sexual:** |  |
| Bleeding  | [ ]  | Excessive Urination  | [ ]  | Abnormal/Missed Menstrual Periods | [ ]  |
| Bruising  | [ ]  | Painful Urination  | [ ]  | Abnormal/Absent Sex Drive  | [ ]  |
|  |  | Difficulty Starting Urination | [ ]  | Delayed/Absent Orgasm  | [ ]  |
| **Pain** (specify location and severity): | [ ]  |  |  | Erection Problem | [ ]  |

**Other Concerns/Problems/Symptoms/Comments** (specify):

**Thank you for faxing or mailing the completed form to me or bringing it to our first appointment.**

Revised 5/15/11

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#### Directions to Offices

San Diego Office:

4550 Kearny Villa Road, Suite 214, San Diego, CA 92123

From the North:

5 South to 805. Exit at Balboa East. Go East about one mile.

Pass over Hwy 163. Left on Kearny Villa Rd. U-turn at first stop light.

Right into Landmark Centre. Go to back building.

From the South:

Hwy 163 North. Exit at Balboa \*West\*. Right at stop light.

Go one half block. Right into Landmark Centre. Go to back building.

Please note: Unfortunately, there is no elevator at this location, and the office is on the second floor. Please let us know if this will present a problem in getting to the office.

\_\_\_\_\_\_\_\_\_\_\_\_

Del Mar Office:

12526 High Bluff Drive, Suite 300, San Diego, CA 92130

Driving Directions:

Interstate 5 to Del Mar Heights Rd exit.

Go East for 0.4 mile.

Take the 1st right onto High Bluff Drive and go 0.4 mile.

Destination will be on the right.

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##### Notice of Privacy Practices

This notice describes how medical information about you

may be used, disclosed and Safeguarded, and how you can get access to this information. Please review it carefully.

# Who is Subject to This Notice

Daniel Gardner, MD, A Professional Corporation

# Our Responsibility

The confidentiality of your personal health information is very important to us. Your health information includes records that we create and obtain when we provide you care, such as a record of your symptoms, examination and test results, diagnoses, treatments and referrals for further care. It also includes bills, insurance claims, or other payment information that we maintain related to your care.

This Notice describes how we handle your health information and your rights regarding this information. Generally speaking, we are required to:

* Maintain the privacy of your health information as required by law;
* Provide you with this Notice of our duties and privacy practices regarding the health information about you that we collect and maintain;
* Follow the terms of our Notice currently in effect.

# Contact Information

After reviewing this Notice, if you need further information or want to contact us for any reason regarding the handling of your health information, please direct any communications to the following contact person:

Daniel Gardner, MD

Suite 214

4550 Kearny Villa Road

San Diego, CA 92123

dgardner@ucsd.edu

##### Notice of Privacy Practices page 2

# IV: Uses and Disclosures of Information

Under federal law, we are permitted to use and disclose personal health information without authorization for treatment, payment, and health care operations. However, the American Psychiatric Association’s Principles of Medical Ethics or state law may require us to obtain your express consent before we make certain disclosures of your personal health information.

Example of using or disclosing health information for treatment:

* A nurse takes your pulse and blood pressure, records it in the medical record, and informs your doctor of the results.

Example of using or disclosing health information for payment:

* We submit a bill to your health insurer to receive payment for your care; the insurer asks for health information (for example, your diagnosis and what care we provided) in order to pay us. In such situations, we will disclose only the minimum amount of information necessary for this purpose.

#  V: Other Uses and Disclosures

# Required By Law

* We may disclose health information about you as required by federal, state, or other applicable law.

# Workers’ Compensation

* We may disclose health information about you for purposes related to workers’ compensation, as required and authorized by law.

Any Other Use or Disclosure -- Authorization Required

* Before using or disclosing your personal health information for any other purpose not identified above, we will obtain your written authorization. Unless action has already been taken in reliance on the authorization, you have a right to revoke such authorization by submitting your request in writing to us (see section III above for contact information).

# VI: Psychotherapy Notes

Psychotherapy notes may be disclosed by a therapist only after you have given written authorization to do so. (Limited exceptions exist, e.g. in order for your therapist to prevent harm to yourself or others, and to report child abuse/neglect). You cannot be required to authorize the release of your psychotherapy notes in order to obtain health-insurance benefits for your treatment, or enroll in a health plan. Psychotherapy notes are also not among the records that you may request to review or copy (see discussion of your rights in section VII below). If you have any questions, feel free to discuss this subject with Dr. Gardner

# VII: Your Health Information Rights

Under the law, you have certain rights regarding the health information that we collect and maintain about you. This includes the right to:

# Notice of Privacy Practices page 3

* Request that we restrict certain uses and disclosures of your health information; we are not, however, required to agree to a requested restriction.
* Request that we communicate with you by alternative means, such as making records available for pick-up, or mailing them to you at an alternative address, such as a P.O. Box. We will accommodate reasonable requests for such confidential communications.
* Request to review, or to receive a copy of, the health information about you that is maintained in our files and the files of our business associates (if applicable). If we are unable to satisfy your request, we will tell you in writing the reason for the denial and your right, if any, to request a review of the decision.
* Request that we amend the health information about you that is maintained in our files and the files of our business associates (if applicable). Your request must explain why you believe our records about you are incorrect, or otherwise require amendment. If we are unable to satisfy your request, we will tell you in writing the reason for the denial and tell you how you may contest the decision, including your right to submit a statement (of reasonable length) disagreeing with the decision. This statement will be added to your records.
* Request a list of our disclosures of your health information. This list, known as an “accounting” of disclosures, will not include certain disclosures, such as those made for treatment, payment, or health care operations. We will provide you the accounting free of charge. However, if you request more than one accounting in any 12 month period, we may impose a reasonable, cost-based fee for any subsequent request. Your request should indicate the period of time in which you are interested (for example, “from May 1, 2003 to June 1, 2003”). We will be unable to provide you an accounting for any disclosures made before April 14, 2003, or for a period of longer than six years
* Request a paper copy of this Notice.

In order to exercise any of your rights described above, you must submit your request in writing to our contact person (see section III above for information). If you have questions about your rights, please speak with Dr.Gardner, available in person or by phone or email, during normal office hours.

# VIII: To Request Information or File a Complaint

If you believe your privacy rights have been violated, you may file a written complaint by mailing it or delivering it to Dr. Gardner (see section III above). You may complain to the Secretary of Health and Human Services (HHS) by writing to Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Avenue, S.W., Room 509F, HHH Building, Washington, D.C. 20201; by calling 1-(800) 368-1019; or by sending an email to OCRprivacy@hhs.gov. We cannot, and will not, make you waive your right to file a complaint as a condition of receiving care from us, or penalize you for filing a complaint

# IX: Revisions to this Notice

We reserve the right to amend the terms of this Notice. If this Notice is revised, the amended terms shall apply to all health information that we maintain, including information about you collected or obtained before the effective date of the revised Notice. If the revisions reflect a material change to the use and disclosure of your information, your rights regarding such information, our legal duties, or other privacy practices described in the Notice, we will promptly distribute the revised Notice, post it in the waiting area(s) of our office, and make copies available to our patients and others.

# X: Effective Date: 11/6/03

# Notice of Privacy Practices page 4

**(Please detach and return this page only. Please keep the rest of this Privacy form)**

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#### Patients’ Acknowledgment of Receipt of

Notice of Privacy Practices

**Patient Name**: \_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Birth date**: \_     \_\_\_\_\_\_\_\_

**Maiden or other name** (if applicable):\_\_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I acknowledge that I have received a copy of the Notice of Privacy Practices of Daniel Gardner, MD, A Professional Corporation, effective 11/6/03**

**Signature** (patient or authorized representative):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date:** \_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship/authority** (if signed by authorized representative): \_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dan Gardner, MD

Psychiatry and Psychoanalysis

Diplomate, American Board of Psychiatry and Neurology

Distinguished Life Fellow, American Psychiatric Association

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 Phone/fax: 858 560 5609 dgardner@ucsd.edu [www.dangardnermd.com](http://www.dangardnermd.com)

Authorization to Use/Disclose Health Care Information

**Patient Name**: \_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Birth date**: \_     \_\_\_\_\_\_\_\_

**Maiden or other name**

(if applicable)\_\_\_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I request and authorize Dan Gardner, MD to release the health care information described below to:

**Name:** \_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Address:** \_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **City, State:** \_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Zip code**:      \_\_\_\_\_\_\_\_\_

This request and authorization applies to only the following protected health information:

during the following time period or dates: \_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Purpose(s) of this use/disclosure:

[ ] \_\_ At the request of the individual

\_[ ] \_ Other:\_     \_\_\_\_\_\_\_\_\_\_\_\_

Authorization expires: at the end of treatment or \_     \_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that, unless action already has been taken in reliance on this authorization, I may revoke this authorization at any time by making a written request to Dan Gardner, M.D.

I understand that Dr. Gardner may not condition treatment, payment, enrollment or eligibility for benefits on my signing this authorization, unless my treatment is related to research and the purpose of this authorization is to enable the protected health information described above to be used for such research.

I understand that my express consent is required to release any health care information relating to testing, diagnosis and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health or drug/alcohol treatment or use.

**Signature** (patient or authorized representative)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date:** \_\_\_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship/authority (if signed by authorized representative): \_\_\_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# (Please keep a copy of this form.)

Revised 3/8/15