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](mailto:dgardner@ucsd.edu) [www.dangardnermd.com](http://www.dangardnermd.com)

**Registration Information**

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Patient’s Legal Name | | | | | | | | | | | | | |
| LAST | | FIRST | | | | | MIDDLE | | | | | | |
| Permanent Address  STREET 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 Address  Street | | | | 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 | | | | | | | | | | | | |

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| 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](mailto: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 | |
|  |  | | | | | |  | |
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|  |  | | | | | |  | |
| 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  No  If 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  No  If yes, what kind?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How many drinks per week? \_\_\_\_\_  Are you concerned about the amount you drink?  Yes  No  Have you considered stopping?  Yes  No  Have you ever experienced blackouts?  Yes  No  Are you prone to “binge” drinking?  Yes  No  Do 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  No  Have you ever given yourself street drugs with a needle?  Yes  No | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| All information contained in this questionnaire will be kept strictly confidential. | | | | | | | | | | | | | |
| Sex: | | | Are you sexually active?  Yes  No  If yes, are you trying for a pregnancy?  Yes  No  If not trying for a pregnancy, list contraceptive or barrier method used  Any discomfort with intercourse?  Yes  No  Illness 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  No  Do you have frequent falls?  Yes  No  Do you have vision or hearing loss?  Yes  No  Do you have an Advance Directive and/or Living Will?  Yes  No  Would you like information on the preparation of these?  Yes  No  Physical 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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| MENTAL HEALTH |
| Are you experiencing, or have you had in the past, the symptoms/problems below?  Stress  Yes  No  Depression  Yes  No  Crying easily/ frequently  Yes  No  Attempted suicide  Yes  No  Seriously thought about hurting yourself  Yes  No  Wishes to die  Yes  No  Feelings of hopelessness  Yes  No  Mood swings  Yes  No  Sensitive to rejection  Yes  No  Periods of euphoria/excitement/high energy..............................……………. ……………… .. Yes  No  Irritability  Yes  No  Frequent sadness  Yes  No  Trouble sleeping  Yes  No  Problems with eating or your appetite  Yes  No  Recent weight change  Yes  No  Self-critical thoughts  Yes  No  Restlessness  Yes  No  Loss of interest in work  Yes  No  Temper outburts  Yes  No  Lack of purpose or meaning  Yes  No  Feelings of regret  Yes  No  Feelings of guilt  Yes  No  Fear of dying  Yes  No  Panic/anxiety attacks  Yes  No  Excessive anxiety  Yes  No  Worrying much of the time  Yes  No  Disturbing dreams  Yes  No  Financial worries  Yes  No  Inability to relax  Yes  No  Difficulty expressing feelings  Yes  No  Feelings of failure  Yes  No  Difficulty making decisions  Yes  No  Trouble remembering things  Yes  No  Difficulty thinking  Yes  No  Inability to concentrate  Yes  No  Suspiciousness of others  Yes  No  Acting without thinking  Yes  No  Feelings of unreality  Yes  No  Fear of being in public  Yes  No  Feel cut off from others  Yes  No  Concerns about going crazy  Yes  No  Jealousy  Yes  No  Feelings easily hurt  Yes  No  Try to be perfect  Yes  No  Unable to please others  Yes  No  Divorce  Yes  No  Breaking the law  Yes  No  Lack of friends  Yes  No  Persistent lying  Yes  No  Avoid being alone  Yes  No  Sexual problems  Yes  No  Distressing sexual feelings/thoughts  Yes  No  Frequent short-term relationships  Yes  No  Wish to hurt others  Yes  No  Marital problems  Yes  No  Gambling  Yes  No  Counseling/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  No  Number of pregnancies       Number of live births  Are you pregnant or breastfeeding?  Yes  No  Have you had a D&C, hysterectomy, or Cesarean section?  Yes  No  Any urinary tract, bladder, or kidney infections within the last year?  Yes  No  Any blood in your urine?  Yes  No  Any problems with control of urination?  Yes  No  Any hot flashes or sweating at night?  Yes  No  Do you have menstrual tension, pain, bloating,  irritability, or other symptoms at or around time of period?  Yes  No  Experienced any recent breast tenderness, lumps, or nipple discharge?  Yes  No  Date 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  No  Any blood in your urine?  Yes  No  Do you feel burning discharge from penis?  Yes  No  Has the force of your urination decreased?  Yes  No  Have you had any kidney, bladder, or prostate infections within the last 12 months?  Yes  No  Do you have any problems emptying your bladder completely?  Yes  No  Any difficulty with erection or ejaculation?  Yes  No  Any testicle pain or swelling?  Yes  No  Date 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): \_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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