



**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