A L I S A L A N D , M . D .
2 0 0 1 B A R R I N G T O N A V E N U E , S U I T E 3 0 1
L O S A N G E L E S , C A 9 0 0 2 5
3 1 0 - 4 2 8 - 2 8 3 3
F A X 8 8 8 - 5 5 8 - 6 6 9 3

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

The undersigned authorizes the release and exchange of medical, psychiatric, substance abuse records and/or information on _____, DOB_____

To /or/ by Alisa Land, M.D. from /or/ to:

_____.

This authorization is limited to the following types of information: any records which Alisa Land, M.D. or the above noted clinician has concerning psychotherapy and/or medication management, which he or she rendered to: _____

The medical records release pursuant to this authorization may be used for the following purposes:

Diagnosis and Treatment

This authorization shall remain valid

_____ until treatment ends or

_____ until _____.

Notice to Patient: You have the right to receive a copy of this authorization.

Name: _____ **Signature:** _____
(Please print)

Date: _____