NIRMAL SINGH BRAR, MD. , Inc.
Child, Adolescent & Adult Psychiatry
1111 E. Hendon Ave., Suite 115
Fresno, CA 93720
(559) 376-7921 ext 108 FAX (559) 335-4214

Patient Name:_____ Date of Birth :_____

I hereby authorize you to discuss/disclose the specific information described below, only for the purposes and parties also described below.

Description of the specific information to be discussed:

❑ Appointment Date/Times, ❑ Visit Summary, ❑ Diagnosis,

❑ Alcohol/Drug Information, ❑ Mental Health,❑ HIV Information

❑ Medications,❑ Test/Results, ❑ Care Plan, ❑ Other (specify)

❑ All of the Above

_____
Information will be discussed with the following:

Name:_____
Relationship:_____
Phone:_____

I understand that:
● I may revoke this authorization in writing by contacting your office.
● This authorization is only to discuss/disclose information.
● This authorization is giving Nirmal S Brar MD the right to discuss my medical information with the one or more people listed above.
● If I would like a copy of my medical record, a release of information will still be required.

_____ _____
Patient's Signature (If Adult) Date Signed

_____ _____
Guardian/Legally Authorized Representative of Patient Date Signed