Renaissance Behavioral
MEDICINE

Release of Records Authorization

I, _____(Patient's Name and Date of Birth) authorize _____ (Keeper of Patient's Psychiatric Records) to release my psychiatric medical records solely to:

Renaissance Behavioral Medicine
Dr. Kenneth Etefia M.D.
1650 South Amphlett Boulevard Ste 203 San Mateo, CA 94402
P:650-206-8932 F:855-347-9258

This authorization is valid for 12 months (Time Period) and is strictly for the purpose of Medical Treatment /continuation of Care (Purpose of Release).

Patient's Name: _____
Date Signed: _____
Signature:

Or, if patient is below 18 years old:

Patient's Name: _____
Legal Guardian/ Representative: _____
Date Signed: _____
Signature: