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Octave Behavioral Health

Authorization for Release of Two-Way Health Information

Legal Name: Michael Andrew Gasio

Date of Birth: 11/14/1952

Phone Number: 559-287-9955

Address:
9432 Pier Dr. Huntington beach Ca. 92646

I, Michael Anderw Gasio, authorize the disclosure of my health information to and from the following parties:

Organization Name		**Organization Name**	Octave Behavioral Health
Provider/ Individual Name		**Provider Name**	
Address		**Corporate Office**	625 Market Street, San Francisco, CA 94105
Phone		**Phone**	415-360-3833
Fax		**Fax**	628-234-3048
Email (optional)		**Email (preferred)**	support@findoctave.com

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1. The category of information to be released includes the following (check all that apply)
   - [x] Billing Records
   - [ ] Insurance Information
   - [x] Chart Summary
   - [ ] Treatment Notes
   - [x] Treatment Summary
   - [ ] Clinical Assessment(s)
   - [ ] Other:

2. The purpose of this health information release and/or exchange includes (check all that apply)
   - [ ] Coordination of care
   - [ ] Insurance or billing requirement
   - [ ] Healthcare operations
   - [x] Legal requirement
   - [ ] Disability case
   - [ ] Other:

3. Date range of the information to be released (month/date/year):

   from 01/01/2024 to 01/20/2025 .

4. Unless otherwise revoked, this authorization will expire 12 months from signed date or
   - [ ] Custom date:

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5. Acknowledgements (check ALL):
   - ☑ All items on this form are completed.
   - ☑ My questions about this form are answered
   - ☑ I will receive a copy of this form

I, or my authorized legal representative, request that health information regarding my care and treatment be released as set forth on this form. I understand that:

- This authorization may include disclosure of information relating to mental health treatment only if I sign this form. I specifically authorize release of such information to the person(s) indicated above.
- With some exceptions, health information once disclosed may be re-disclosed by the recipient. If I am authorizing the release of mental health treatment information, the recipient is prohibited from re-disclosing such information or using the disclosed information for any other purpose without my authorization unless permitted to do so under federal or state law.
- I have the right to revoke this authorization at any time by writing to the provider listed above.
- I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

Signing this authorization is voluntary. I understand that my treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditional upon my authorization of this disclosure.

Signature of Client or Representative _____ Date: 1/23/2025

Print name if other than the Client: _____

Relationship to patient of representative: _____