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Authorization for Release of Information

_____ _____
Patient Name (print) Signature

_____ _____
Date Of Birth Todays's Date

O Release Information to **O** Obtain Information from **O** Exchange Verbal Info

_____
Name of Person or Organization

_____
Address

_____ _____
Telephone Number Fax Number

_____
Reason for Disclosure

Information To Be Disclosed :

_____ General Information
_____ Medication History
_____ General Progress Notes
_____ Labs
_____ Initial Psychiatric Assessment
_____ Medical Discharge Summary
_____ Psychological Testing
_____ Other

Information NOT T0 Be Disclosed:

_____
_____
_____

Please Note: All consents to release health information will expire in 180 days unless specified here. _____