Permission to Release Information

I,_____DOB_____SSN_____

hereby grant permission for:_____

_____

_____

to release the following information: ___Psychiatric Evaluation
___Psychological Evaluation
___Discharge Summaries
___Laboratory Studies
___Reports of Clinical Studies: EKG EEG
___Sessions Notes
___Narrative Summary of Treatment
___All Psychiatric Information
___Other_____
specify

for the purpose of: ___Continuity of Treatment
___Third Party Review
___Employment
___Other_____
specify

to: _____

_____

_____

I fully understand that the release of information may entail the release of personal and perhaps sensitive information including information regarding drug and alcohol use, HIV and Aids status. This permission may be revoked by a signed, dated, and witnessed document.

_____ _____
Patient ***date***

_____ _____
Parent/Legal Guardian (if pt under age 19) ***date***

_____ _____
Witness ***date***

this release expires 6 months from date signed by patient