



CONVENTIONS PSYCHIATRY & COUNSELING

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AUTHORIZATION TO RELEASE MEDICAL RECORDS

I hereby authorize: _____ to release to:

Name of Doctor/facility/Patient: _____

Address: _____

Phone: _____ Fax: _____

RECORDS PERTAINING TO:

Patient Name: _____ SS#: _____ Date of Birth: _____

CHECK INFORMATION TO BE RELEASED:

All psychiatric treatment (Psych Evals, Progress Notes, Medications, Lab Results)

From _____ Through _____.

Psychological of Neurological test results

Hospital Dictated Reports (History and Physical, Discharge Summary, etc.)

Other (Specify materials to be released) : _____

This authorization is valid for _____ days from the date below. I understand that I can withdraw this consent at any time by submitting a written request. This information is confidential and further disclosure by the receiving party is prohibited without written consent. I have read and understand the above statement. I release CONVENTIONS PSYCHIATRY & COUNSELING of all legal liability that may arise from this disclosure.

Patient Signature: _____

Date: _____

Parent/Guardian Signature: _____

Date: _____

Witness Signature: _____

Date: _____

(Patient must sign if 12 years or older along with parent /guardian)