Your Family Psychiatrist

Authorization for Release of Information

I hereby authorize: _____

To: ____ Release Information to: _____

____ Obtain Information from:_____

____ Exchange information with:_____

Name: _____

Address: _____

Telephone: _____

The information requested or authorized for release or exchange pertains to:

Medical/Mental Health Records

Education/Educational Testing

Lab Studies

Drug or Alcohol Abuse

This authorization is valid until _____. I may cancel this authorization at any time by signing, dating, and writing "CANCEL" on this original form or by sending a written, signed, and dated request to the doctor above indicating my desire to cancel. Once my information has been released by Your Family Psychiatrist, PLLC, the recipient might re-disclose it. Your Family Psychiatrist, PLLC has no control over your released information and privacy laws may no longer protect it. I understand that the purpose of this authorization is to improve the quality of my mental health evaluation or treatment.

_____ _____

Patient's Name Date of Birth

_____ _____

Patient's Signature Date

_____ _____

Parent/Guardian's Signature (if patient is a minor) Date

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