Shlakman Psychiatric Services, PLLC

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Authorization for Release of Medical Information

I hereby authorize the release of information from the medical record of:

Patient Name: ________________________________ Date of Birth: ________________________

Daytime Phone #: ______________

Information Released

To: ____(name/phone#)

From: ____ (name/phone#)

Please Release the Following:

_____ Problem List
_____ History/Physical Exam
_____ Other Diagnostic Reports (Specify) ___________
_____ Progress Notes
_____ Lab Reports
_____ Other (Specify)

Including information (if applicable) pertaining to:

_____ Mental Health _____Drug/Alcohol _____HIV/AIDS

Purpose of Need for Disclosure:

_____ Patient Care _____ Legal Evaluation _____ Insurance Claim/Application
_____ Other (Specify) _________________________

I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited. I further understand that I may revoke this consent (in writing) at any time except to the extent that action has been taken.

_______________________________________ _____________
Signature of Patient or Legal Representative Date

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:

I understand that my medical record may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold Shlakman Psychiatric Services, PLLC liable for any misinterpretation of the information in my medical record as a result of not consulting my physician for the correct interpretation.

_______________________________________ ____________
Signature of Patient or Legal Representative Date