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RELEASE OF INFORMATION

I, _____, hereby give my permission to have _____ communicate with and release and/or receive any and all records and information that pertains to:

Name: _____ Date of Birth:_____

To: (Name)_____

Address: _____

The purpose of this disclosure is

_____ Facilitating evaluation and/or treatment

_____ Coordinating treatment

_____ Other (Specify) _____

My consent is valid until: _____ or further revoked.

I understand that I may revoke my consent in writing at any time and that our office has the right to inspect and copy the information disclosed. I understand that the refusal to consent to the release of this information may lead to incomplete or inaccurate conclusions or delay in the completion of the evaluation or treatment. Refusal to consent means no information will be released.

_____ _____
Signature of Patient Signature of Minor Patient (age 12-17)

_____
Signature of Parent/Guardian

*** If the patient is twelve (12) years of age or older, the patient <u>MUST</u> sign this form. If the patient is under eighteen (18) years of age, the parent or guardian must also sign the form.**

_____ _____
Date of Consent **Witness Signature**