

Authorization to Release Confidential Information

I hereby request that the following information be released by Comprehensive Psychiatric Associates:

- Outpatient Mental Health Evaluation & Treatment (entire record)
- Telephone consultation regarding past or current medical or mental health evaluation/treatment
- Other _____

Please Release to _____

Address _____

Name of Patient _____ Date of Birth _____

Address _____

Your Name _____

Address _____

Your Phone Number _____

I have carefully read and understand the above and do herein expressly and voluntarily consent to disclosure of the above information and/or medical records, including Alcohol & Drug Abuse records, if relevant, to/by those persons/agencies named above. I understand that this information may be protected by Federal Regulation 42 CFR, Part 2. I understand that this consent is subject to revocation at any time except after the information has already been released and will expire one year from the date signed.

Please Note: Parent only may sign for patient 15 yrs old or under. Patient and parent must sign for patient 16 or 17 yrs old.

Signature of Parent or Guardian

Name of Parent or Guardian, printed

Relationship to Patient: father mother other _____

Signature of Patient

Date of Signature