

Authorization to Exchange Confidential Information

To: _____

I hereby request that the following information be Released TO Comprehensive Psychiatric Associates:

- | | |
|--|--|
| <input type="checkbox"/> Most Recent Physical Exam & Laboratory Reports | <input type="checkbox"/> Laboratory Reports |
| <input type="checkbox"/> Hospital Discharge Summaries | <input type="checkbox"/> Outpatient Mental Health Evaluation/Treatment |
| <input type="checkbox"/> Hospital Admission Summaries | <input type="checkbox"/> Records of Medical Evaluation & Treatment |
| <input type="checkbox"/> Hospital Medical History & Physical Exam | <input type="checkbox"/> Records of Core Evaluation |
| <input type="checkbox"/> Neurological Consultation | <input type="checkbox"/> Other School Reports _____ |
| <input type="checkbox"/> Psychological, Neuropsychological,
Developmental, & Academic Testing Reports | <input type="checkbox"/> Telephone consultation regarding past or current
medical or mental health evaluation/treatment |

Other _____

Dates of Services: From _____ to _____

Please release to: Comprehensive Psychiatric Associates, 372 Washington Street, Wellesley, MA 02481

I hereby request that the following information be Released BY Comprehensive Psychiatric Associates:

- | | |
|--|--|
| <input type="checkbox"/> Outpatient Mental Health Evaluation/Treatment | <input type="checkbox"/> Telephone consultation regarding past or current
medical or mental health evaluation/treatment |
| <input type="checkbox"/> Psychological, Neuropsychological,
Developmental, & Academic Testing Reports | |
| <input type="checkbox"/> Other _____ | |

Please release to: _____

Re: Name of Patient _____ Date of Birth _____

Address _____

I have carefully read and understand the above statements 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.

Signature of Parent or Guardian

Name of Parent or Guardian, printed

Relationship to Patient: father mother other _____
(Parent only may sign for patient 15 years old or under. Patient and parent must sign for patient 16 or 17 years old.)

Signature of Patient

Date

Signature of Witness

Date