CONSENT TO RELEASE INFORMATION
Psychiatric Associates

Client Name:_____ Client Date of Birth:_____

Client Social Security Number:_____

Client Address:

_____
Street Town/City State Zip Code

Records to be released, including written, electronic and verbal communication:

__All Healthcare, including treatment and medicines
__Billing or payment information
__Other:_____
__Limit to the following date(s) or type(s) of information:_____

I authorize Psychiatric Associates to: Release my information to:__ Obtain my information from:__

Name:_____

Address:_____
Street Town/City State Zip Code

Fax No., where applicable: _____

Please allow the office(s) named above to disclose my information for the following purpose(s):

□ Coordination of Care □ Letter or Form □ Financial, Insurance or Legal
□ Moving/Transferring care □ Other

Please initial any category **NOT** to be released:

____ Substance Abuse ____ Mental Health ____ HIV/AIDS information ____ Genetic Tests

I SPECIFICALLY AUTHORIZE disclosure and redisclosure of this confidential information to the person or entity listed above with the full knowledge that this Authorization expires one year from the date the Authorization is signed or upon the minor's age of majority. In order for the information to be released, you must sign below.

_____ _____
Signature of Client or Representative Date

_____ _____
If not the client, name of person signing Authority to sign on behalf of client

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