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CONSENT TO RELEASE MEDICAL INFORMATION

I, ________________________________, BIRTH DATE ____/____/____,
hereby authorize __________________ to have bilateral exchange of information that is contained in my medical record with:
____
____
____
under the conditions listed below:

1. This information will be limited to:
   ____ Psychiatric/medical/alcohol/drug abuse evaluation.
   ____ Psychiatric/medical/alcohol/drug abuse discharge summary.
   ____ Progress notes. ____Psychological testing.
   ____ Psychotherapy notes. ____Educational testing.
   ____ Lab studies. ____Other:
   ____ Medical tests/studies. ____Other:

2. Purpose or need for such disclosure: ______ Continuing care/ Treatment, and/or ____________________________________
   ____.

3. This consent is subject to revocation at any time except to the extent that action has been taken in reliance thereon. If not previously revoked, this consent will terminate upon ____.
4. An additional consent must be obtained for any other transfer or disclosure of this information.
5. I understand that I may receive a copy of this release.

______________________________________ ___________________
Patient's Signature Date

______________________________________ ___________________
Signature of Parent, Guardian or other Person authorized by law to sign in lieu of Patient (where required). Indicate which. Date

______________________________________ ___________________
Witness (if applicable) Date