PSYCHIATRIC MEDICINE ASSOCIATES

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AUTHORIZATION TO RELEASE OR EXCHANGE INFORMATION

PATIENT INFORMATION

Name: _____

Address: _____

City, State, ZIP: _____

Date of Birth: _____ Phone Number: _____

OTHER PARTY

Name of Person/Organization: _____

Address: _____

City, State, ZIP: _____ Phone: _____ Fax: _____

INFORMATION TO BE RELEASED

I hereby authorize Psychiatric Medicine Associates to (please initial all that apply)
_____Release Information to _____Gather Information from _____Exchange Information with

PMA Provider: _____

This information may consist of the following (please initial each line to which consent is given):
_____Psychological test reports
_____Psychiatric evaluation reports
_____Periodic reports of psychotherapy
_____Social History Data (family, education, employment, arrest, drugs, and alcohol)
_____Medical Information
_____Other (specify): _____
This information will be used (please initial each line to which consent is given):
_____To determine appropriateness of treatment
_____To develop a diagnosis and treatment plan
_____To facilitate coordination of services
_____At the request of the individual
_____Other (specify): _____

ACKNOWLEDGMENT

I understand that no information may be forwarded by either party listed in this release to any other individual or agency without my written consent. I understand that this information may not be redisclosed by its recipient. This authorization may be revoked at any time by my written statement except to the extent that authorized persons who are to disclose the information described above have already taken action in reliance on it. It is automatically revoked 30 days after the termination of the therapeutic relationship.

This consent is given voluntarily, without coercion. Signing this form is not required to receive treatment/services at Psychiatric Medicine Associates.

_____ _____
Client Date Staff Signature Date