



AUTHORIZATION FOR RELEASE OF INFORMATION

Releasing Facility/Clinician

Phone

Address

Fax

I hereby authorize the above facility/clinician to release the following information:

- Dates of Service
- Psychiatric Evaluation and Treatment
- Mental Health Treatment Plan
- Substance Abuse Assessment/Treatment
- HIV Status, Test Results and Treatment
- Summary of Contacts
- Progress Notes
- Psychological Test Reports
- Discharge Plan
- Medical History, Diagnoses, Treatment

For the purpose of : _____

I understand that this information may be transmitted in the following mode(s):

Written Oral Facsimile Other: _____

It has been explained to me that if I refuse to consent to this release of information the following are the consequences: _____

This consent is valid until: _____

I understand that if I wish to revoke authorization for this release of information, I must do so in writing. I also understand that I have a right to inspect such information as I have authorized to be released.

Patient Name (Print)

Patient Signature

Date

Date of Birth

Witness Signature (if necessary)

Date

Please send records to:
Meridian Psychiatric Partners, L.L.C.

- ATTN:
- Sara M. Gotheridge, MD
 - Daniel Fontaine, LCPC
 - Leigh Deutsch, LCSW
 - Curt Kearney, LCPC
 - Hossam Mahmoud, MD
 - Flavio Arana, MD
 - Michael Raida, MD
 - Daniel Kim, MD
 - Kate Ruhl, MD
 - Andrew McLeod, PhD
 - Gretchen Doninger, PhD
 - Leo Barriga, LCSW
 - Elise Rehn, MD
 - Sue Kehias, LCPC

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