A L I C E W. L E E, M D, A B I H M

Consent for Release of Information

Patient: _____ Birth date: _____

I hereby authorize _____, located at

(Name of previous provider or therapist)

_____to release information from

(Address)

the records of _____. The information is to be released

(Name of patient)

to Alice W. Lee, MD, ABIHM for the purpose of facilitating treatment.

The nature of the information to be released is:

___ Verbal Exchange of Information
___ Progress Notes
___ Psychiatric Evaluation
___ Psychological Evaluation
___ Treatment Summary
___ Discharge Summary
___ School Records
___ Other: _____

I understand that I may revoke my consent to release information at any time, except to the extent that the action will have been taken on information prior to the revocation of my consent. Otherwise, this consent is valid from the date of signature.

Patient Name: _____
(Print name)

Patient Signature: _____ Date: _____

Parent/Guardian Name: _____
(Print name)

Parent/Guardian Signature: _____ Date: _____

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