Ann E. McNeer, Ph.D.

REQUEST FOR INFORMATION

I, _____, hereby request that the person/entity listed below release to Dr. Ann E. McNeer information contained in my/my child's healthcare records.

Name Phone/Fax

Address

I am releasing this information for the purpose(s) of :

_____

_____

The information I would like released includes:

Intake information _____
Discharge information_____
Medication history _____
Family history _____
Psychosocial background _____
Progress Notes _____
Prognosis _____
Educational history _____
Results of testing _____
Legal history _____

Dr. McNeer would like this information in the following form:

Telephone consultation _____
Written Summary _____
Copies of actual notes/reports _____
Other: _____

I understand that this release of information is good for six (6) months or until _____

_____. I may withdraw my consent for the release of information at any time, however information already released will not be affected.

Patient Name: _____

Signed by: _____

Print Name: _____Date: _____

Relationship to Patient: _____

Witness: _____

1004 Bombay Lane ▪ Roswell, Georgia 30076 ▪ Phone (770) 621-5099