Michele Z. Abbasi, M.D.

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AUTHORIZATION FOR RELEASE OF INFORMATION

Accounting of Disclosures Tracking Form

I, _____ **OR**
Print Name of Patient Birthdate Birthday

I,_____
If patient is under 18 years of age print Name of **Parent(s) or Guardian**

hereby authorize:
Michele Z. Abbasi, M.D.

to exchange my personal health information with:

_____
Name of Agency/Person/Organization Address (No. Street, City, State & Zip) Telephone No. and Fax No.

Other:

_____
Name of Agency/Person/Organization Address (No. Street, City, State & Zip) Telephone No. and Fax No.

with the knowledge that such contact discloses the fact that mental health/substance abuse services have been/are being provided. This disclosure of information is required for the following purpose(s):

Evaluation Treatment Planning/Course Other_____

and will consist of the following types of information_____

Entire Record	**Dates and Results** of Medical Assessments and Diagnoses, Lab Tests, EEG, EKG
Medication History	Results of Psychological Testing
Discharge Summary	Educational Information
Legal Information	Other _____

The information and records released pursuant to this consent will not be used for any other purpose.

This consent becomes effective _____. This consent may be revoked by the undersigned at any time **in writing**. If not revoked, it shall terminate at the end of treatment with Dr. Abbasi. I understand that I may receive a copy of this authorization. There is a risk that the person receiving information or documents pursuant to this authorization may re-disclose the information and documents in a manner which will no longer provide protection for the information and documents.

_____ Date: _____ /_____/_____
Signature of Client Month Day Year

_____ Date: _____/_____/_____
Signature of Parent, Guardian or Conservator Month Day Year

_____ Date: _____ /_____/_____
Signature of Other Parent (if legally necessary) Month Day Year

RECORD OF RELEASE OF INFORMATION

_____ _____
Released By (Name and Title) Date Released

All requests for release of information must be in writing. If there are any parties to which you do not want to release this information, please complete a Request for Special Privacy Protection (HF 04a).