** RELEASE OF INFORMATION FORM**

I, _____, hereby authorize Treat-ADHD.com, PLLC to release my health information as described below.

1. INFORMATION TO BE RELEASED (check all that apply):

- ☐ Health records
- ☐ Laboratory reports
- ☐ Consultation notes
- ☐ Other: _____

2. PURPOSE OR NEED FOR DISCLOSURE (check at least one):

- ☐ Personal use
- ☐ Consultation with another healthcare provider
- ☐ Insurance purposes
- ☐ Other: _____

3. INFORMATION TO BE RELEASED TO:

Name: _____
Address: _____
City/State/ZIP: _____
Phone: _____
Fax: _____

4. DURATION:

This authorization shall remain in effect until _____ (date) or until the purpose for this authorization has been fulfilled.

5. RIGHT TO REVOKE:

I understand that I have the right to revoke this authorization at any time by notifying Treat-ADHD.com, PLLC in writing. The revocation will not affect any actions taken before the receipt of this written notification.

6. REDISCLOSURE:

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

7. SIGNATURE:

I have read the above and authorize the disclosure of my health information as stated.

_____ _____ _____

Signature of Patient or Representative Date Relationship to Patient