INSIGHT

PSYCHIATRY

**Consent for Release of Information**

Patient's Name: _____

I authorize Insight Psychiatry LLC and the following persons/agencies listed below to disclose and share confidential information about me. This confidential information includes, but is not limited to: my alcohol and drug use history, psychological/psychiatric history, medical history; family history, legal and financial status, treatment history, results of diagnostic tests, urine tests, and clinical progress reports; current or planned treatment I may receive; all aspects of my treatment and clinical progress; and, all other information deemed important by Jill Husson Martinez, MD to assist with my treatment and/or other personal or business matters including but not limited to insurance reimbursement, legal action, regulatory action, marital conflict, child custody, etc.

I authorize release of this information to and from the following persons, organizations, and/or agencies:

Psychiatrist:_____ Your initials:_____

Psychologist or other therapist:_____ Your initials:_____

Primary care physician: _____Your initials:_____

Family members (specify): _____Your initials:_____

Others (specify):_____Your initials:_____

I acknowledge that this consent can be revoked by me in writing and that I can do so at any time for any reason except to the extent that: (a) this information is deemed necessary to protect my personal safety and/or the safety of others who may be seriously affected by my behavior; (b) disclosure has already occurred; and, (c) any pending action already taken and/or in progress that relies on this disclosure.

Patient's signature: _____ Date signed:_____