Laura Rocker M.D.

Child, Adolescent, and Adult Psychiatry

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Phone: 216-765-3220
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Release of Information

Client Name:	**Date of Birth:**
Address:	**Home #:**
	Cell #:
	Work #:

I hereby authorize Dr. Laura Rocker to:

	Release information to:		**Receive Information from:**

Name:	
Address:	**Home #:**
	Cell #:
	Work #:

Person or place that is requesting/receiving information:

	Patient/Parent/ Guardian		**Doctor/Hospital**		**Lawyer**		**Insurance Company**
	Other:						

Reason records are needed:

	Patient Care		**Disability**		**Insurance**		**School**
	Legal		**Other:**				

Treatment dates:

This authorization expires one year from the date of signature or on this date/event:

I understand that medical records might have information about sexually transmitted disease (STDs), acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It might also have information about mental health problems or services, and/or treatment for alcohol or drug abuse

I understand that if I release records to someone other than a doctor, insurance company, hospital or other health-related organization, these records may no longer protected by the Federal privacy regulations, and this person or organization might release the records to someone else.

I understand that I can revoke or cancel this Authorization at any time, but this does not apply to records that were already releases. If I want to revoke it, I must notify Dr. Laura Rocker in writing.

Signature of Patient/Parent/Legal Guardian	**Printed Name of Patient/Parent/Legal Guardian**	**Date:**
Signature of Witness	**Printed Name of Witness**	**Date:**