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DIPLOMATE OF PSYCHIATRY, AMERICAN BOARD OF PSYCHIATRY & NEUROLOGY
DIPLOMATE OF ADDICTION MEDICINE, AMERICAN BOARD OF ADDICTION MEDICINE
DIPLOMATE OF FORENSIC PSYCHIATRY, AMERICAN BOARD OF PSYCHIATRY & NEUROLOGY

AUTHORIZATION TO RELEASE INFORMATION

I, _____, hereby authorize David Taylor M.D. to exchange information with and/or release copies of my psychiatric and medical record(s) pertaining to my treatment to:

_____
NAME OF PERSON OR ORGANIZATION

_____
ADDRESS OR PHONE

☐ All relevant and timely information may be released.

Only the following information may be released:

☐ Initial clinical summary
☐ Progress notes
☐ Medication records
☐ Other _____
☐ Laboratory results
☐ Substance abuse treatment
☐ Psychological testing

These records are required for the purpose of continuity of clinical care. This release will expire one year from the date signed unless otherwise noted.

I certify that I have read this form and that I understand its contents.

_____ _____
PATIENT SIGNATURE DATE OF AUTHORIZATION