AUTHORIZATION TO RELEASE COPIES OF MEDICAL RECORD AND/OR FOR VERBAL COMMUNICATION FROM ANOTHER AGENCY

Neogen Psychiatry, P.A.
Child, Adolescent, and Adult Psychiatry
2141 Kirkwood Blvd, Ste 130, Southlake, TX 76092
Ph: (817) 442-3112; FAX: (817) 251-8844

Patient's Full Name: ________________________________Date of Birth: _____________

____is authorized to release information to:
(DR/AGENCY/PERSON)

DR GENE FLETCHER at 2141 Kirkwood Blvd, Ste 130, Southlake, TX 76092

Regarding care in the following manner (check 1 or both):

_____Verbal Discussion _____Send Copy of Medical Record

Release information for the time period of: _____ to _____OR_____All episodes of treatment.

Information released is for the following purpose:
______Follow up Care ______Personal Use ______Legal
______School ______Disability ______Family Involvement
______Other

I authorize the following portions of the above person's medical record be released to the above listed recipient:
_____Admission History/Initial Evaluation _____Lab Reports
_____Physical Exam/Medical Consultations _____Psychosocial Evaluation
_____Physician Progress Notes _____Substance Abuse Assess.
_____Family Therapy Notes _____Group Therapy Notes
_____Discharge Summary _____Nursing Notes
_____Discharge Order Form _____Physician Orders

I understand these records include drug/alcohol/mental health/communicable disease-related information. I understand that information released could contain reference to results of HIV antibody testing. A photocopy of this authorization should be considered as valid as the original. This consent is subject to revocation by the undersigned at any time, except to the extent that action has been taken in reliance hereon and in any even shall expire within 90 (ninety) days from the date of signature. The information being authorized to release is being disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). A general authorization for the release of medical or other information is not sufficient for theis purpose. The information to be released is PRIVILEGED and CONFIDENTIAL and is intended ONLY for the use of the recipient named above.

______________________________ ____________________ __________
Signature of Patient or Legal Guardian Relationship to Patient Date