New Journey Psychiatry
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CONSENT TO RELEASE

PSYCHIATRIC/ MEDICAL RECORDS

I, (**client**) _____, BIRTH DATE ____/____/____,hereby authorize New Journey Psychiatry, PLLC to have bilateral exchange of information that is contained in my medical record with:_____ under the conditions listed below:

1. **(Optional)** This information will be limited to:
   ____ Psychiatric/medical/alcohol/drug abuse evaluation.
   ____ Psychiatric/medical/alcohol/drug abuse discharge summary.
   ____ Progress notes. ____Psychological testing.
   ____ Psychotherapy notes. ____Educational testing.
   ____ Lab studies. ____Other:
   ____ Medical tests/studies. ____Other:

2. Purpose or need for such disclosure:
   __X__ Continuing care/Treatment,
   and/or _____.

3. (Optional) This consent is subject to revocation at any time except to the extent that action has been taken in reliance thereon. If not previously revoked, ***this consent will terminate upon termination of care*** OR _____.
   (Specific Date, Event or Condition)

4. An additional consent must be obtained for any other transfer or disclosure of this information.

5. I understand that I may receive a copy of this release.

_____ _____
Patient's Signature Date

_____ _____
Signature of Parent, Guardian or other Person authorized by law to sign in lieu of Patient (where required). Date

_____ _____
Witness (if applicable) Date