**RELEASE OF CONFIDENTIAL INFORMATION**

**I, Patient Name**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date of Birth**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hereby authorize\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Provider Name**

Who is a healthcare provider at: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Name of Medical Office**

**to release the following information regarding my medical/healthcare (Be Specific):**

* **Including Drug/Alcohol Abuse Treatment Information (42 C.F.R Part II)**

to Dr. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ who is a healthcare provider at **Medical Psychology Associates**, for the purpose of:

I understand that:

* **This information will be kept for one year from the signed date below**.
* **The information will not be used for purposes other than its intended use.**
* ***Scott D Wylie, Psy.D., MSCP, LLC dba Medical Psychology Associates* is not authorized to release or disclose information to any other person/entity without my written consent.**
* **I may revoke this authorization at any time.**

***Patient*** or ***Legal Guardian/Parent*** Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_