**RELEASE OF CONFIDENTIAL INFORMATION**

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

Hereby Authorize:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Name

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

Name of Medical Office/Facility

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:

***Please fax all requested records or documentation to Dr. Scott Wylie at (970) 223-4433 unless prior arrangements have been agreed upon***

By signing below, I agree to 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:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_