Wellness Psychiatry
& Psychosocial Oncology

Wellness Psychiatry

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AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I [Name of patient] _____ DOB: _____

hereby authorize [Name of provider] _____

_____

to release confidential information obtained during the course of my treatment to [Name of person or entity to which information is to be released] _____

_____

This authorization permits the release of the following information:

_____Any and all information necessary

_____Diagnosis _____Treatment Plan

_____Prognosis _____Clinical Test Results

_____Summary of Treatment _____Labs

_____Other: _____

_____

I understand that I am giving consent to release the above specified information and/or medical records of my condition to those persons or agencies listed above. This may include diagnosis and treatment of psychiatric illness, alcohol abuse, and/or drug abuse.

I understand I have a right to receive a copy of this authorization. I also understand any cancellation or modification of this authorization must be in writing.

This authorization shall remain valid until: _____

_____ _____

Signature of Patient Date

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