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Release of Confidential Information

_____ _____
Patient Name **Birthdate**

☐ From Dr. Bingham, to the person or organization named below
☐ To Dr. Bingham, from the person or organization named below
(I recommend checking both boxes if the person or organization is still involved)

_____
Person or Organization

_____

This confidential information may be shared for:
☐ Coordination of treatment
☐ Other: _____

I understand that all records from Dr. Bingham are considered "mental health records." The following types of records may be shared including information about drug and alcohol use.

- Assessments & Summaries
- Visit chart notes
- Laboratory and other test results
- Medication records

I understand that I may revoke this consent at any time, though obviously this would not affect information already released. Unless revoked earlier, Dr. Bingham may release information to the person or organization named here until one year after the file closes with Dr. Bingham. I understand that revocation must be made in writing, addressed to and delivered either to Dr. Bingham in person or by certified mail.

As parent, legal guardian, or adult patient, I authorize the release and exchange of confidential information regarding the patient named above.

_____
Please Print Your Name & Relationship to the Patient

_____ _____
Please Sign Your Name Date