RELEASE

Authorization for Release of information

I give Michael J. Feldman MD permission to contact and get history and information from the following people / institutions:

Name _____ Telephone Number _____

Name _____ Telephone Number _____

Name _____ Telephone Number _____

I hereby authorize Michael J. Feldman MD to:

☐ Release information to:
☐ Obtain information from:
☐ Exchange information with:
Name _____ Telephone Number _____

☐ Release information to:
☐ Obtain information from:
☐ Exchange information with:
Name _____ Telephone Number _____

☐ Release information to:
☐ Obtain information from:
☐ Exchange information with:
Name _____ Telephone Number _____

The information requested or authorized for release or exchange pertains to:
☐ Mental Health ☐ Education ☐ HIV / AIDS ☐ Sexually transmitted diseases ☐ Drug or alcohol abuse

This authorization is valid for 90 days from the date below or _____, (not to exceed 1 year). I may cancel this authorization by signing, dating, and writing "CANCEL" on this original form or by sending a written, signed and dated request to the doctor above indicating my desire to cancel. I understand that once my information has been released, the recipient might re-disclose it, my doctor has no control over it and privacy laws may no longer protect it. The purpose of this authorization is to improve the quality of my mental health evaluation or treatment.

Signature _____ Date _____

Printed Name _____ Date of Birth _____
Relationship to Patient: ☐ Self ☐ Parent ☐ Legal Guardian