KAUR PSYCHIATRIC ASSOCIATES, P.A.

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If records are more than 20 pages, please MAIL

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____ _____ _____
(Name of Client) (Date of Birth) (Social Security #)

Authorize

_____
(Name and address of person or agency releasing the information)

To release to:

_____
(Name and address of person or agency to whom the information is to be released)

The following information:

Date(s) of Service: _____

Transfer / Discharge Summary: _____ Progress Notes: _____

Psychiatric Assessment / Evaluation: _____ Lab Reports: _____

Physical Examination: _____ All Medical Records: _____

Other, please specify: _____

For the following purpose: _____

I understand that my records are protected under the Federal and State Confidentiality regulations and cannot be released without my written consent unless otherwise provided for in regulations. Federal regulations prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. I also understand that I may revoke this consent (in writing) at any time unless action has already been taken based upon it.

This information authorized for release may include records which may indicate the presence of a communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS), as well as any drug / alcohol related data. I understand that this consent is valid for (1) year from the date signed and that I can revoke it at any time. I further acknowledge that the information to be released was fully explained to me and this consent is given of my own free will.

_____ _____
Date Signature of Client

_____ _____
Signature of Witness Signature of Parent, Guardian, or Authorized Representative