Dr. Dana Reid, LLC
Child, Adolescent and Adult Psychiatrist

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CONSENT FOR RELEASE OF INFORMATION

Patient Name Date of Birth

I _____________________, hereby authorize Dr. Dana Reid to release information from my medical records as described below to

Name:____

Address:____

Phone Number:____________________ Fax:___________________________________

The request and authorization applies only to the following information:

_____Medical History/Physical Exam _____Laboratory Reports _____Consultations
_____Discharge Summary _____Summary of Hospitalizations _____Progress Notes
_____Psychiatric Reports/Tests _____Psychological Reports _____Teachers' Reports
_____Psychiatric Evaluation _____Medications _____Social History
_____Treatment Recommendations _____Course of Treatment ____Developmental Hx
Other_____________________________________

The purpose of the release of information is: ____Coordination of Care _____Continuation of Care

The release will expire in 12 months unless specified by you.
I understand that I can cancel this authorization at any time, except for action that has already been taken.

____ ____________________
Signature of Patient (12 years and older) Date

____ ____________________
Signature of Guardian Date