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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

TO: _____

_____

_____

I, _____, hereby request and authorize Dr. Perlman to discuss with the above named party general medical information pertaining to the evaluation and treatment given to me by the health care provider listed above. I authorize the release of information pertaining to HIV, substance use and Hepatitis C infection if such information is part of my medical record.

- In addition to general medical information, I request and authorize the release of any information pertaining to the following areas I have indicated below with my initials:

  Psychiatric/Mental Health Records____ HIV Test Results _____
  Substance Use History_____

- The parties may use the medical and other information so authorized for the purpose of a psychopharmacological evaluation.
- This Authorization covers treatment dates from _____ to _____.
- This Authorization is effective immediately and will expire on _____.
- I understand I may revoke this consent at any time, and that I have a right to receive a copy of this Authorization on my request.

_____ _____
Patient Name *Patient Signature and Date*

_____ _____
Patient Address *Patient Date of Birth*

_____ Please send recent labs, medication list and problem list. Full chart *not* necessary.