

## Consent to Release Confidential Information

I \_\_\_\_\_ hereby authorize and request,

Dr. Melissa Jenkins

to release confidential information, including personal, psychological, psychiatric, drug/alcohol, medical records and opinions, resulting from my contacts with the above to:

\_\_\_\_\_ Name: \_\_\_\_\_

Title/Functions: \_\_\_\_\_

\_\_\_\_\_ Address: \_\_\_\_\_

\_\_\_\_\_ \_\_\_\_\_

Disclosure may include the following specific types of information: Health, Medical, Neurologic, Psychiatric, Substance Abuse and Psychosocial history and tests, Psychological Tests, Neuropsychological Tests, Treatment Plan, Laboratory Data including HIV Test.

This information may be released by telephone/verbal, mail, photocopy, or facsimile.

\_\_\_\_\_

Do Not Release: \_\_\_\_\_

Use of this information shall be limited to the following purpose(s):

Patient care, treatment coordination, and at the request of the individual for his own purposes.

I have reviewed the Privacy Notice pertaining to this information, and have been offered a copy.

I understand that any cancellation or modifications of this authorization must be in writing, and that I have a right to receive a copy of this authorization. A photocopy of this authorization shall be as effective and valid as the original.

This authorization shall remain valid until revoked by the signer.

I furthermore release all parties stated here within from any legal liability resulting from the release of this information, with the understanding that all parties involved will exercise appropriate safeguards while using this information.

Signature \_\_\_\_\_ Date \_\_\_\_\_

