Linder Psychiatric Group, Inc.
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Hours of operation 7:30am-5:00pm Clinicians Pagers/Cell Phone Available 24 hrs
Website: www.echildpsychiatry.com

AUTHORIZATION FOR THE EXCHANGE OF MEDICAL RECORD INFORMATION: MEDICAL/PSYCHIATRIC/DRUG/ALCOHOL INFORMATION

Regarding Records of:_____ **Date of Birth:**_____

Information to be released FROM:
Name: _____

Address: _____

Phone: _____

Fax: _____
Information to be released TO:
Name: _____

Address: _____

Phone: _____

Fax: _____
For the purpose of (specify):
_____
I understand that the information shared between the above parties may include:

- Mental health/psychiatric treatment information and history, including history of alcohol and/or substance abuse, medical records, and lab reports.
- Treatment dates, diagnoses, medications prescribed, and admissions to hospitals, outpatient centers or other facilities.
- Evaluation and treatment plan.
- This authorization is effective immediately and will remain in effect for 365 days from the date of signing (not to exceed one year) or unless specifically terminated in writing.
- I realize that this is a required consent and that I must voluntarily and knowingly sign this authorization before any records can be released, and that I may refuse to sign. I further release my treating provider and employees of the treating provider from any liability arising from the release of information to the person(s)/agency as designated above.

_____
Patient/Parent/Authorized Representative: **Date:**