FRONT RANGE PSYCHIATRY

# RELEASE OF INFORMATION FORM

Name_____ Date of Birth _____

This form authorizes Dr. Newman and Front Range Psychiatry to release and exchange health information to/with the following providers/entities (please list name and phone/fax)

1._____

_____

2._____

_____

3._____

_____

This information can include:
□ Copies of evaluation/progress notes
□ Testing/lab results
□ Treatment plan (including medications) and summary (written and verbal)
□ All of the Above
□ Other (Specify):

This authorization shall remain in effect until the end of treatment unless another end date is specified:
Date:_____ Initials: _____

I understand that I may revoke this consent at any time by notifying this office in writing. Such revocation will not extend to release of information that has already occurred from this authorization.

_____ _____
Signature required (patient or guardian) Date

_____
Printed name of patient (or representative and relationship to patient)