Reno Psychiatric Associates

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CONSENT TO RELEASE INFORMATION

I authorize _____

Address: _____

To release to: _____

Address: _____

The following information:

_____

From the medical record of:

_____
(Patient's name and date of birth)

The information is to be released for the following purpose, and that purpose only. Any other use is forbidden:

_____

This consent will expire on _____ or until _____ expires.

Information given or received pursuant to this consent is confidential. Further disclosure to other persons or agencies is strictly forbidden by Federal Law without the specific written consent of the patient, with the exception of program or physical audit where such information is kept confidential.

I understand I may revoke this consent at any time. Only the original signature of the patient will be honored.

SIGNATURE: _____ **DATE:** _____
WITNESS: _____ **PARENT/GUARDIAN:** _____