

**AUTHORIZATION FOR RELEASE OF PSYCHIATRIC AND
MEDICAL RECORDS AND CONFIDENTIAL INFORMATION**

I, _____, an adult individual over the age of eighteen (18) years, hereby authorize _____ or any agent or employee of _____ to release to my designee, _____ only, any and all psychiatric and/or medical records and confidential information which it has in its possession concerning any and all treatment, treatment plans, medical history, confidential information and psychiatric records of my condition(s). I specifically release said person(s) or institution(s) from any and all medical and legal obligations to protect otherwise confidential medical and psychiatric information.

I hereby request this release for the purpose of permitting the above person(s) or institution(s) to inform my designee of the nature, cause and treatment of my psychiatric condition, and to discuss any otherwise confidential information related to my condition(s). I also request that my designee be informed of any medication that I have been prescribed and the reasons for such prescription, as well as any side effects caused by the medication.

THIS RELEASE SHALL EXPIRE ONLY UPON MY WRITTEN AUTHORIZATION.

Dated: _____

Signature

Witness

Sworn and Subscribed before me this

___ day of _____ 2008.

Notary Public