Zafar Rehmani, M.D.

Child and Adult Psychiatrist

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CONSENT FOR RELEASE OF INFORMATION

(PLEASE PRINT)

I_____BORN ON_____

(PATIENT NAME)

HEREBY AUTHORIZE THE ABOVE NAMED PARTY TO DISCLOSE TO:

NAME_____

(WHO DO YOU WANT RECORDS RELEASED TO?)

ADDRESS:_____

CITY, STATE, ZIP CODE_____

THE FOLLOWING INFORMATION: _____

(WHAT INFORMATION DO YOU WANT RELEASED?)

FOR THE PURPOSE OF: _____

(WHY DO YOU NEED THE RECORDS?)

PLEASE GIVE DATES OF SERVICE:_____

(IF ALL PLEASE WRITE ALL)

MY NAME AT THE TIME WAS: _____

(MAIDEN NAME ETC.)

I UNDERSTAND THAT MY MEDICAL RECORDS (including any mental, drug abuse or alcohol abuse information) MAY BE PROTECTED BY FEDERAL RECULATION. I ALSO UNDERSTAND THAT I MAY REVOKE THIS CONSENT AT ANY TIME EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN O IT AND THAT IN ANY EVENT THIS CONSENT EXPIRES AUTOMATICALLY AS DESCRIBED BELOW. A COPY OF THIS AUTHORIZATION WILL BE AS VALID AS THE ORIGINAL

SPECIFICATION OF THE DATE, EVENT OR CONDITION OF EXPIRATION (IF LEFT BLANK EXPIRES ONE YEAR FROM DATE)

I UNDERSTAND THAT IF THE FEE IS NOT PAID BY THE REQUESTOR I WILL BE RESPONSIBLE.

I FULLY UNDERSTAND THE ABOVE:

_____ _____

Signature Date

_____

Nature of Relationship (if not patient)

_____ _____

Witness Date