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RELEASE OF INFORMATION

PATIENT'S NAME: _____ DOB: _____

The patient listed above hereby authorizes **Roy Michael Stefanik, DO**

☐ to disclose to ☐ to receive from

Name of individual/organization:

_____

Address of individual/organization:

_____

Fax Number: Phone Number:

(_____)_____ (_____)_____

Specific dates needed: _____.

These disclosures are for the purposes of **(please check all that apply)**:

___ Continued Care ___ Evaluation ___ Consultation ___ Other: _____

The specific records/reports to be disclosed shall include:

___ Psychiatric Records
___ Emergency Records
___ History & Physical
___ Discharge Summary
___ Psychological Testing
___ Verbal Authorization
___ Urine Drug Screen
___ EKG
___ CT/MRI/X-Ray
___ Legal Documents
___ Labs/Blood Work
___ EEG
___ Complete Records
___ Pharmacy Profile/Meds
___ Other (specify type): _____

I understand this information is protected by federal and state confidentiality laws and may not be disclosed without authorization or unless required or permitted by law. This information is for release of medical records and information including diagnosis, treatment, and/or examination related to mental health (psychiatry or psychology), or drug and/or alcohol abuse. I also understand that I may revoke this authorization at any time, and unless earlier revoked, this authorization will expire on ____/____/_____. If no date or event is specified, authorization will expire 1 (one) year after the date of the signature below.

_____

Patient Signature **Date**