AT Psychiatry, PLLC
CHANGE YOUR MIND!

Authorization to Release/Exchange Confidential Information

This form cannot be used for the re-release of confidential information provided to AT Psychiatry, PLLC, by other individuals or agencies. Such requests should be referred to the original individual or agency.

I, (print name) _____, authorize AT Psychiatry, PLLC, to:

_____ release to:
_____ obtain from:
_____ exchange with:

_____

_____

_____

_____

the following information pertaining to myself:

_____ treatment summary
_____ history/intake
_____ diagnoses
_____ psychological test results
_____ psychiatric evaluation/medication history
_____ dates of treatment attendance
_____ other (specify) _____

for the purpose of:

_____ evaluation/assessment and/or coordinating treatment efforts
_____ other (specify) _____

This consent will automatically expire one (1) year after the date of my signature as it appears below, or

on the following earlier date, condition, or event: _____.

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

_____ Social Security #: _____
Signature of Client Date OR
Date of Birth: _____

_____
Signature of Witness Date

Initials _____