DRS. GAULT, FISHBEIN, & ASSOCIATES

AUTHORIZATION TO RELEASE AND/OR RECEIVE INFORMATION

NAME: _____

ADDRESS: _____

I hereby authorize _____ , at Drs. Gault, Fishbein, and Associates, to release to and/or receive
(Name of Doctor)
from _____ the following information from my ____ clinical; ____ medical; ____ school;

____ other file for the purpose of treatment planning.

___ medical/physical history	___ psychological evaluation	___ social assessment
___ psychiatric evaluation	___ neuropsychological evaluation	___ educational report
___ lab report	___ psychoeducational report	___ vocational assessment
___ discharge summary	___ chemical dependency evaluation	___ progress reports
___ other (specify)		

The purpose of this disclosure is to facilitate continuity of care.

This consent form expires on ____/____/____. Your doctor and the person or place listed above can only exchange the information you have checked off in the list above. We cannot release the information to anyone else, and we can only use the information to help with your assessment or treatment. You may withdraw your consent for us to communicate with the other person or place at any time, in writing. If you withdraw your consent, it applies to new information, not to information we have already exchanged. You have the right to see and copy any information exchanged. You further understand that your refusal to consent to the release of information specified above will prevent disclosure of such information to the facility or individual named on this consent form.

DATE: _____ * _____
(Patient) 18 years or older

DATE: _____ * _____
(Parent/Guardian) Under 18 years

DATE: _____ * _____
(Witness)

Authorization to release information and/or limit disclosure and/or revoke consent may be abrogated by and/or superseded by court order and/or applicable Federal and/or State law(s), including the Abused and Neglected Child Reporting Act.