

Family Psychiatry and Psychology Associates, P.A.

1400 Crescent Green, Suite 120, Cary, NC 27518

Office: (919) 233-4131 Fax: (919) 233-4168

Seth E. Tabb, M.D.

Amanda S. Dorn, M.D.

Jennifer D. Siddle, M.D.

Lisa Hayutin, Ph.D.

Sheryll A. Daniel, Ph.D.

SAMPLE Release of Information

I, Person signing this form, consent to allow all clinicians of Family Psychiatry and Psychology Associates, P.A. listed above to release and/or exchange information regarding

Patient Name

Date of Birth

(Client)

(Date of Birth)

This information will include: *(Check appropriate boxes for types of information to be shared)*

Psychiatric Records

Psychological Testing

Procedures

Therapy Notes

Medical Records

Laboratory Work

Educational Records

Other _____

Discharge Summary

All of the above

Information can be shared with the following people/agencies (please include address):

Names, addresses and/or phone number(s) of people with whom information may be shared

I understand that this information will be used in the client's best interests to benefit current psychiatric and psychological evaluation and/or treatment. I understand that the information exchanged will be handled in a professional and confidential manner.

It is the policy of FPPA not to release those materials provided by physicians from outside this office regarding the patient's former or current care. You may obtain second party records by contacting the source directly. Second party records will only be released when such records are no longer available from the original source.

I also understand that I may revoke this consent at any time except to the extent that action based on this consent has already taken place.

Signature: Sign here Witness: Please have witness sign here

Relationship to Client: Relationship to patient of person who signs Date: Date of signature

This consent is valid until Optional. If I fail to specify an expiration date, this authorization will automatically expire 12 months from the date of signature.

Rescind Consent: I hereby rescind the prior consent granted to Family Psychiatry and Psychology Associates, P.A. to release and/or discuss any information with the individual(s)/agencies listed above.

Signature: _____ Date: _____