AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

The Doctor's Office at 83 S Main.

83 S. Main St. Lexington, TN 38351 Phone: 731-798-5056

Fax: 731-798-5059

This form cannot be used for the re-release of confidential information provided to the Doctor's Office by other individuals or agencies. Such requests should be referred to the original individual or agency.

marviadar or agency.		
I	(DOB:) authorize the
I		
release to:		
obtain from:		
exchange with:		
		_
the following information pertaining to	o myself:	
treatment summary		
history/intake		
diagnosis		
lab/imaging test results		
psychiatric evaluation/m	nedication history	
dates of treatment attend	lance	
all records for a period of other (specify)	-	<u> </u>
for the purpose of:		
evaluation/assessment a	nd/or coordinating treatme	nt efforts
other (specify)		
I understand I have the right to refuse time (except to the extent that the information)		
Signature of Client	Date	