VALERIE T. RELACION, M.D., PC

ADULT, CHILD, AND ADOLESCENT

PSYCHIATRIST

Authorization for Release of Medical Records or Information

1. PATIENT INFORMATION

Patient Full Name: _____

Patient Date of Birth: _____

Patient Address: _____

2. I AUTHORIZE:

Valerie T. Relacion, M.D., PC
Adult, Child, and Adolescent Psychiatrist

TO: ☐ release information to ☐ obtain information from ☐ exchange information with

3. ORGANIZATION/INDIVIDUAL INFORMATION

Organization Name: _____

And/or Person Name: _____

Address:_____

Phone Number:_____

Fax Number or Email Address (**REQUIRED**):_____

4. INFORMATION TO BE RELEASED

☐ Entire Medical Record	☐ Lab Work	☐ Educational Information
☐ Medication List Only	☐ Testing	☐ Information for Billing Purposes
☐ Progress Notes	☐ Oral Conversation Only	
☐ Other Assessments ----------		

**This authorization includes information relating to ALCOHOL, DRUG ABUSE, MENTAL HEALTH TREATMENT and CONFIDENTIAL HIV RELATED INFORMATION. ____ (initials)

5. EXPIRATION

This authorization ends on (date/time frame) _____ or when treatment is terminated.

6. SIGNATURE

Signature of patient (16 years of age and above) _____

Signature of parent (patients under 18 years of age): _____

Date: _____

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