**CONSENT FOR RELEASE & RETRIEVE OF MENTAL HEALTH**

**INFORMATION**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\**Please Note: If consultation is requested and information is to be*

*exchanged between this provider and a third party, the name, address and*

*phone number of the designated third party should be listed in both the*

***RELEASE*** and ***RETRIEVE*** *section below\*\**

I hereby consent **Susan Lurie MD** **to *RELEASE***

INFORMATION TO THE FOLLOWING PARTIES. This includes written

and verbal transfer of history, as well as mental health and treatment

information for the purposes of consultation and coordination with relevant

professionals.

These Individuals are as follows:

Name Address Phone Number and Fax

I hereby consent to **Susan Lurie MD** to ***RETRIEVE***

INFORMATION FROM THE FOLLOWING PARTIES. This includes

written and verbal transfer of history, as well as mental health and treatment

information for the purposes of consultation and coordination with relevant

professionals.

These Individuals are as follows:

Name Address Phone Number and Fax

**AUTHORIZATION:**

I certify that this authorization to release and/or

retrieve has been made voluntarily. I understand the information to be released and/or retrieved may include information related to drug abuse,

alcoholism or alcohol abuse. The released and/or retrieved information may

also include psychiatric conditions.

I understand that I may revoke this authorization at any time by giving

written notice to **Susan Lurie MD** except to the extent that **Susan Lurie MD**

has already taken action on this request. This

authorization will expire six months from the date treatment is terminated.

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Signature of Patient or Guardian /Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Date

I am revoking consent and authorization to request or release information.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Guardian/Date