Uptown Psych

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Release of Information

Patient Name: _____

Address: _____

_____

Date of Birth: _____

I authorize and request _____ and office staff at Uptown Psych to release or receive confidential information; including but not limited to psychiatric, medical, laboratory, psychological testing data and interpretation, social, educational, substance abuse, clinical information, diagnoses, and any other information (in oral, written, electronic, and any other form) regarding his or her contact with myself to/from:

Name: _____

Address: _____

_____

Phone: _____

Fax: _____

I likewise authorize and request the same about named person(s) to release any said information to Uptown Psych. This authorization is valid indefinitely, unless retracted by the undersigned in writing.

_____ _____

Patient Signature: Date: