EMPATHIC RESONANCE, LLC

EMPATHY DRIVEN INDIVIDUALIZED & HOLISTIC CARE ©

ADULT, CHILD & ADOLESCENT PSYCHIATRIC CONSULTATIONS & SERVICES

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firas@empathic-resonance.org

CONSENT FOR RELEASE OF PATIENT INFORMATION

Name: _____ DOB: _____

Address: _____ Telephone: _____
_____

I hereby authorize Empathic Resonance, LLC to: release AND obtain specified information in my medical/patient/educational record for the purpose of continued medical care to and from:
Individual, Facility, or Organization: _____
Address: _____
Phone Number: _____
Fax Number: _____
Information to be Used or Disclosed include the available items checked below:

____ Hospitalization ____ Consultation Report ____ Discharge Summary ____ Labs
____ Initial Evaluation ____ History & Physical ____ Treatment Notes ____ Other
____ Psychological Testing

I understand that my medical records and/or information in my connection with the hospitalization/treatment date(s) used for medical care may contain mental health, development disabilities, alcohol and drug abuse, and/or Acquired Immune Deficiency (AIDS)/HIV test results which are privileged and confidential and may be disclosed only on my authorization, except as required by law.

I UNDERSTAND THAT THIS CONSENT IS REVOKABLE AT ANY TIME PRIOR TO THE RELEASE OF THIS INFORMATION.

I agree to release and hold harmless Empathic Resonance LLC, directors, officers, and employees from any and all liability, damages, claims, or suits, including reasonable attorney's fees, in connection with the disclosure of the records/information as authorized herein.

Patient Signature _____ Date_____
Guardian's Signature _____