



Noam Koenigsberg, MD • 960 West 41st Street Suite 410 • Miami Beach, 33140 • (1)305-814-4992

Release of Information

Client's Name: _____

I authorize Dr. Noam Koenigsberg and the following persons/agencies listed below to disclose and share confidential information about me. This confidential information includes but is not limited to, current or planned treatment provided by Dr. Koenigsberg, my alcohol and drug history, psychiatric history, medical history, family history, legal history, results of diagnostic tests, blood tests, urine tests, clinical progress reports; all aspects of my treatment and clinical progress and all other information that Dr. Koenigsberg deems important to assist with my treatment and/or other personal business matters including but not limited to payment reimbursement, insurance reimbursement, legal action, regulatory action, marital conflict, child custody, etc.

I authorize the release of this information to and from the following persons, organizations and/or agencies:

Client's initials: _____

Previous or current psychiatrists, psychologists and/or therapists:

Name: _____

Title: _____

Address: _____

Phone Number: _____

Fax Number: _____

Client's initials: _____

Previous or current psychiatrists, psychologists and/or therapists:

NK

Noam Koenigsberg, MD • 960 West 41st Street Suite 410 • Miami Beach, 33140 • (1)305-814-4992

Name: _____

Title: _____

Address: _____

Phone Number: _____

Fax Number: _____

Client's initials: _____

Previous or current medical doctors:

Name: _____

Title: _____

Address: _____

Phone Number: _____

Fax Number: _____

Client's initials: _____

Previous or current medical doctors:

Name: _____

Title: _____

Address: _____

Phone Number: _____

Fax Number: _____

NK

Noam Koenigsberg, MD • 960 West 41st Street Suite 410 • Miami Beach, 33140 • (1)305-814-4992

Client's initials: _____

Family Members:

Name: _____

Relationship: _____

Address: _____

Phone Number: _____

Fax Number: _____

Client's initials: _____

Family Members:

Name: _____

Relationship: _____

Address: _____

Phone Number: _____

Fax Number: _____

Client's initials: _____

Attorney:

Name: _____

Title: _____

Address: _____

NK

Noam Koenigsberg, MD • 960 West 41st Street Suite 410 • Miami Beach, 33140 • (1)305-814-4992

Phone Number: _____

Fax Number: _____

Client's initials: _____

Others:

Name: _____

Relationship: _____

Address: _____

Phone Number: _____

Fax Number: _____

I acknowledge that this consent can be revoked by me in writing and that I can do so at any time for any reason except to the extent that: (1) this information is deemed necessary to protect my personal safety and/or the safety of others who may be seriously affected by my behavior; (2) disclosure has already occurred; (3) any pending action already taken and/or in progress that relies on this disclosure.

Client's Signature: _____

Date Signed: _____