JENNIFER C. HEATH, M.D.
Diplomat of the American Board of
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6410 Southwest Blvd., Suite 101
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817/735-1888
817/735-4122 (FAX)

AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Patient: ____

Date of Birth: ____

I, the undersigned, authorize Dr. Jennifer C. Heath to send, receive or give verbal and written information to/from the following pertaining to any medical, psychological, alcohol/drug abuse, social, vocational, and/or educational information concerning the above patient.

Primary Care Physician: ____
____

Current/past Psychiatrist and/or Therapist(s): ____
____

Hospital(s): ____
____

Other: ____
____

The reason for release of information is for continuity of care.

This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by (42 C.F.R. Part 2). The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

I understand that my records are confidential and can not be disclosed without my written authorization, except when otherwise permitted by law. Unless otherwise specified, this Release Form will remain in effect until discharge from Dr. Jennifer C. Heath's care.

Date: ____________________ Signature: ____
Patient or Legal Representative

____Patient declines to sign release of information. ____
Staff Signature