Gene Fletcher D.O., P.A.
Child, Adolescent, and Adult Psychiatry

566 N. Kimball Ave, Ste 110 Ph: (817) 442-3112
Southlake, TX 76092

RELEASE OF INFORMATION
AUTHORIZATION TO RELEASE COPIES OF MEDICAL RECORD AND/OR FOR VERBAL COMMUNICATION

Patient's Full Name: _____Date of Birth: _____

_____ is authorized to release information regarding
(Name of Facility Releasing Information)
care in the following manner (check 1 or both): ___Verbal Discussion
___Send Copy of Medical Record

Release information for the time period of: _____ to _____OR_____All episodes of treatment.

Information is to be released to: Dr Gene Fletcher, 566 N. Kimball Ave, Ste 110, Southlake, Texas, 76092. Ph: (817) 442-3112 or FAX: _____

Information released is for the following purpose:
_____Follow up Care _____Personal Use _____Legal
_____School _____Disability _____Family Involvement
_____Other

I authorize the following portions of the above person's medical record be released to the above listed recipient:

_____Admission History/Initial Evaluation	_____Lab Reports
_____Physical Exam/Medical Consultations	_____Psychosocial Evaluation
_____Physician Progress Notes	_____Substance Abuse Assess.
_____Family Therapy Notes	_____Group Therapy Notes
_____Discharge Summary	_____Nursing Notes
_____Discharge Order Form	_____Physician Orders

I understand these records include drug/alcohol/mental health/communicable disease-related information. I understand that information released could contain reference to results of HIV antibody testing. A photocopy of this authorization should be considered as valid as the original. This consent is subject to revocation by the undersigned at any time, except to the extent that action has been taken in reliance hereon and in any even shall expire within 90 (ninety) days from the date of signature. The information being authorized to release is being disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). A general authorization for the release of medical or other information is not sufficient for theis purpose. The information to be released is PRIVILEGED and CONFIDENTIAL and is intended ONLY for the use of the recipient named above.

_____ _____ _____
Signature of Patient or Legal Guardian Relationship to Patient Date