CONSENT FOR RELEASE OF INFORMATION

I, _____ (name) whose date of birth is _____,

Address _____

Do authorize Mary L. Wyant, MD PA to disclose and/ or obtain from:

_____ (name of person or organization).

Phone no:_____Fax No:_____

Initial each item to be disclosed:

___Assessment
___Psychological Evaluation
___Treatment Update
___Participation in Treatment
___Drug Screens
___Discharge Summaries
___Progress in Treatment
___Diagnosis
___Psychiatric Evaluation
___Medication Management
___Educational Information
___Demographic Information
___All of the Above

The purpose of this disclosure is to improve assessment and treatment planning and coordinate treatment services. If other purpose please specify: _____.

I understand I have a right to revoke this authorization in writing at any time by sending written notification to Mary L Wyant MD PA at the above address. I further understand that revocation of the authorization is not effective to the extent that action has already been taken in reliance on the authorization.

Unless sooner revoked, this consent expires on the following date: _____, or as otherwise indicated _____. I understand that Mary L Wyant MD PA will not condition treatment on whether or not I consent to disclosure. It has been explained to me that failure to authorize disclosure may have the following consequences: Limiting clarification of past medical history or treatment history.

Unless specifically requested in writing that the disclosure be made in a certain format, the right is reserved to disclose information as permitted by this authorization in any manner deemed appropriate and consistent with applicable law, including, but not limited to: verbally, electronically, or in a paper format.

Federal Law prohibits the person or organization to whom the disclosure is made from making further any further disclosure of substance abuse treatment information, unless it is expressly permitted by written authorization or as otherwise permitted by 421 C.F.R Part 2

I will be given a copy of the authorization for my records upon request.

Signature of Patient _____ Date _____

_____ Date _____

Signature of Parent, Guardian or Personal Representative

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