Raluca Radulescu, MD, LLC

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Consent for Release of Information

Patient's Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ DOB: _____

I, _____ , authorize_____ to:

_____ (send) ____ (receive) the following ____ (to) ____ (from)

Name: _____Phone:_____

Address: _____ City: _____ State: _____ Zip: _____

____ Clinical information
____ Progress reports
____Psychiatric evaluation
____ Summary reports
____ Entire record, except progress notes
___ Other, specify:

The above information will be used for the following purposes:

____ Planning appropriate treatment
____ Case review
____ Updating files
____ Other (specify) _____

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after 1 year this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

Your relationship to patient: __Self __Parent/legal guardian __Personal representative
__Other (describe)_____

If you are the legal guardian or representative appointed by the court for the patient, please attach a copy of this authorization to receive this protected health information.

Patient's Signature: _____ Date: _____/____/_____

Parent/guardian/personal representative (if applicable)

Signature: _____ Date: _____/____/_____