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AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, hereby authorize Ann Davis, M.D. to exchange
NAME OF PATIENT

information pertaining to my treatment with and/or release copies of my psychiatric and medical records to:

_____
NAME OF PERSON OR TITLE OF ORGANIZATION

_____
ADDRESS AND/OR PHONE NUMBER

The relevant and timely information that may be released is limited to:

- ☐ Initial Clinical Summary
- ☐ Progress Notes
- ☐ Laboratory Results
- ☐ Psychological Testing
- ☐ Verbal Telephone Contact
- ☐ Medication
- ☐ Consultations
- ☐ Other _____

These records are required for continuity of clinical care. This release will be valid until treatment ends, unless otherwise noted.

I certify that I have read this form and that I understand its contents. I also understand that I have a right to receive a copy of this authorization upon request.

_____ _____
NAME (PLEASE PRINT) SIGNATURE

_____
DATE