Release of Information

Exchange of Information is when you, the patient, allow Dr. Antar to receive, release and discuss your information with another party; this can be signed for doctors, therapists, councorlers, parents, etc.

I_____hereby authorize Dr. Laura N. Antar, M.D., Ph.D. to:
(Print Full Name)

Exchange information with:_____Phone_____

Please provide the address and fax of the person above:
Address:_____
_____
Fax (if available):_____

The information requested or authorized for release or exchange pertains to:
Mental Health
Education
Drug or alcohol abuse

This authorization will be valid until it is either revoked by the patient or the patient is discharged from treatment. You may cancel this authorization verbally, or by sending a written, signed and dated request to the doctor above indicating your desire to cancel.

I_____understand that once my information has been released, the recipient might re-disclose it, my doctor has no control over it and privacy laws may no longer protect it. The purpose of this authorization is to improve the quality of my mental health evaluation or treatment.

Patient Name (print):_____Date Of Birth_____

Patient's Signature:_____Date Signed_____

Guardian's Signature (if patient is a minor):_____**Date**_____