AUTHORIZATION TO TRANSFER MEDICAL RECORDS

I hereby authorize **Transformations: Adult & Geriatric Psychiatry PC** to furnish medical

information concerning:

Patient's name: ____

Patient's date of birth: ____

To [clinician's name and address]:

____

____

____

Any and all information may be released, including, but not limited to, mental health records, drug and alcohol abuse records, and HIV test results, if any, except as specifically provided below:

____
____
____

This authorization is effective now and will remain in effect for one year, or until [date:]

I understand that I may receive a copy of this authorization.

Signature of patient or patient's personal representative:

Date of receipt:

Name of personal representative, if applicable:

Representative's relationship to patient: