TRANSFORMATIONS
ADULT AND GERIATRIC PSYCHIATRY PC

I hereby authorize _____ to furnish medical information concerning:

Patient's name: _____

Patient's date of birth: _____

TO: **Transformations Adult & Geriatric Psychiatry**, **PC**, FAX 877-511-8663, or ajb@transformationspsychiatry.net, or Phone 844 647 1455.

Any and all information may be released, including, but not limited to, mental health records, drug and alcohol treatment 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 **Date**
(or patient's representative)

Personal representative information (if applicable):

_____
Name

_____
Relationship to patient