AUTHORIZATION FOR RELEASE OF RECORDS

PATIENT'S NAME: ________________________ DOB:____________________ SSN: ____________________________

I hereby authorize DOGON BEHAVIORAL MEDICAL GROUP, INC., its agents, employees, and/or servants to disclose my psychiatric and/or substance abuse records, and information obtained in the course of my diagnosis and treatment to:

____	____________________________
AGENCY/FACILITY/PHYSICIAN/SCHOOL	ATTENTION OF
____	____________________________
STREET	CITY/STATE/ZIP CODE

Phone:________________________________ Fax:______________________________________

FOR THE FOLLOWING PURPOSES:

- ❑ CONTINUING CARE BY THE RECEIVING FACILITY/DOCTOR/THERAPIST
- ❑ TO ARRANGE FOR RESIDENTIAL TREATMENT
- ❑ ASSISTANCE BY THE RECEIVING AGENCY
- ❑ EDUCATIONAL PLANNING
- ❑ OTHER: ____

SUCH DISCLOSURE SHALL BE LIMITED TO THE FOLLOWING SPECIFIC INFORMATION:

- ❑ PSYCHIATRIC HISTORY & MENTAL STATUS EXAM
- ❑ RESULTS OF PSYCHOLOGICAL TESTS
- ❑ MEDICAL HISTORY & PHYSICAL EXAM
- ❑ LAB & X-RAY REPORTS
- ❑ EDUCATIONAL ASSESSMENT & REPORTS
- ❑ TREATMENT PLANS & UPDATES
- ❑ PROGRESS NOTES
- ❑ CONSULTATIONS
- ❑ TREATMENT SUMMARY
- ❑ OTHER (SPECIFY): ____

This consent is subject to revocation by the undersigned at any time, except to the extent that action has been taken in reliance thereon and if not earlier revoked it shall terminate one year from the date of signing.

Release or transfer of the disclosed information to any person or entity not specified herein is prohibited by law. An additional consent must be obtained for further usage or transfer of disclosed information.

I understand that I have the right to receive a copy of this authorization if I so request.

I am fully aware that certain State and Federal Statues and Regulations require that I voluntarily and knowingly sign this document before DBMG/DPS can release any records, and that I may refuse to sign my signature, but in that event the record cannot and will not be released or disclosed by DBMG /DPS.

Dated: ___________ ____
SIGNATURE OF PATIENT

Dated: ___________ ____
SIGNATURE OF PARENT/GUARDIAN/AUTHORIZED REPRESENTATIVE OF PATIENT (indicate which)

Dated: ___________ ____
WITNESS

Dated: ___________ ____
SIGNATURE OF PHYSICIAN/THERAPIST (when applicable)

NOTICE OF REVOCATION

I, ____________________________, hereby revoke my authorization of this disclosure of information to the agency/person listed above. This revocation effectively makes null and void any permission for disclosure of information expressly given by the above authorization. I understand that any actions based on this authorization, prior to revocation, will not be affected.

Signature of Patient/ Parent/
Guardian/Legal Rep: ____________________________________ Date: __________________

Signature of Witness: ___________________________________ Date: __________________