Medical Release Form

Date_____

By signing this authorization, I authorize Alicia Salzer, M.D. to receive/use and/or disclose the following protected health information (PHI) about me to:

_____(Name of practitioner)

_____(Address of practitioner)

_____(Phone/email of practitioner)

For the purpose of_____
(ie. Continuity of care, at the request of the individual, disability, employment, etc)

This authorization permits Alicia Salzer, MD to receive/use and/or disclose the following individually identifiable health information about me

- ☐ Any psychiatric information including notes, diagnosis, dates of service, etc.
- ☐ Summary report of psychiatric treatment
- ☐ Complete Medical/Psychiatric record (written/verbal documentation) including urinary drug screen results.

☐ Other (please specify)

I release you from all legal responsibilities or liabilities that may arise from this authorization. This authorization expires on (**unless there is a date written in the space provided, THIS RELEASE is valid for one year from the date printed below**). When my information is disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. I do not have to sign this authorization to obtain treatment.

No ☐ Yes ☐ Patient's Initials _____

Signature of patient or legal guardian _____

(Patient Name- Please print) _____

Contact Number _____

Date _____

To revoke this authorization you must submit a request in writing to the address above.