AUTHORIZATION TO RELEASE AND/OR RECEIVE CONFIDENTIAL INFORMATION

Amy Alson, MD • 205 E. High St., Charlottesville, VA 22902
Phone: 434-984-1100 • Fax 434-260-3853

I, _____, date of birth _____, authorize Amy R. Alson, MD, at the above address, to:

A) Release to, receive from, and or exchange my clinical information with the following **healthcare provider**. This authorization will remain valid indefinitely unless it is rescinded. You may rescind this authorization in writing, at any time.

Name_____
Address_____
Phone_____ Fax: _____

B) Release clinical information to the following individuals (ie, family member, school administrator, friend). You may revoke this authorization in writing at any time.
Name_____
Address_____
Phone_____ Fax: _____

Your signature, below, expresses your understanding of and agreement with these terms, confirms that you understand that records to be released or information to be shared pertains to your psychiatric and general medical health and relevant treatment, and that this authorization does not pertain to communication related to financial transactions, which is unrestricted indefinitely.

_____ _____
Signature of patient or legal guardian Date

Print name: _____