AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

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I hereby authorize **Dr. Henry Crabbe, MD** to ☐ obtain my records from ☐ send my records to:

Name: _____

Address: _____

_____

Phone: _____ Fax: _____

Regarding:

Name: _____ DOB: _____

- Psychological
- Psychiatric/Clinical Psychological
- Medical
- Addiction Services
- Other: _____

This authorization will expire 12 months from the date this document is signed or on an alternate date to be specified: _____.

By signing below, I acknowledge that I have been fully informed of, and understand that this request for my consent, and I give my permission for the identified information to be obtained; and

I understand that my consent is voluntary and may be revoked in writing at any time. I also understand that revocation is not retroactive (i.e., does not negate an action that occurred after the consent was given but before receipt of the written documentation that consent was revoked).

_____ _____
Patient Name Patient or Legal Guardian Signature

_____
Date Signed