David J. Schopick, M.D.
118 Maplewood Avenue, Portsmouth, New Hampshire 03801
Telephone: (603)431-5411 / Facsimile (603)430-9085

AUTHORIZATION FOR RELEASE OF MEDICAL/PSYCHIATRIC INFORMATION

Patient Name_____DOB:_____/_____/_____

_____
Street Town/City State Zip

I hereby request and authorize: David J. Schopick, M.D. or his staff,

To obtain from/exchange with (including telephone or facsimile):

Name of Person/Provider: _____

Agency_____

Address_____
Street Town/City State Zip

Telephone #:_____ Fax #_____

I am hereby authorizing and approving the release of the following type(s) of confidential psychiatric information pertaining to me to the individual and/or agency listed above:

_____ All records, notes, or any other information requested without any limitation;

or, only the following records:

_____ Drug and Alcohol History
_____ Progress Notes
_____ Treatment Plans
_____ Initial Psychiatric Evaluation
_____ Lab Reports
_____ Discharge Summary
_____ Summaries
_____ Records from the following dates of service: Start date _____ to end date _____
_____ Other_____

I understand that all information I have authorized to be obtained or exchanged will be held strictly confidential and cannot be released by either of the two parties names above without my written consent. I have been advised to inform Dr. Schopick's office if this release should be withdrawn and considered void at a future date.

This release expires one year from the signature date below unless a shorter period is specified here _____.

_____ _____
Signature of Patient/Parent/Guardian **Date**