

## *Authorization to Release Confidential Information*

I, \_\_\_\_\_, authorize  
(Print your full name above)

**Ernest Madhavan, MD**  
**Soundview Psychiatric Services, PLLC**  
**14030 NE 24<sup>th</sup> Street, Suite 104, Bellevue, WA, 98007**  
**Phone (425) 637-3976**  
**Fax (425) 671-0209**

to release information in my medical record to:

**Name:**

**Phone Number:**

**Fax Number:**

**Mailing Address:**

Only the following information may be released (please initial items you wish to have released):

\_\_\_\_\_ Summary of diagnosis and treatment

\_\_\_\_\_ Photocopies of all medical records

\_\_\_\_\_ Other (please specify below)

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I understand that my express, written consent is required to release any health care information relating to psychiatric disorders or mental health problems, and drug, alcohol or other substance use or abuse. This consent agreement indicates my waiver of confidentiality with regards to the named party above and the above marked items

This released information may be used solely for health care treatment or legal purposes. This authorization expires in 120 calendar days from the date on which the client signed it. It may be revoked at any time by written, signed, and delivered request.

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(Signature of patient)

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(Date signed)