

Authorization to Release Confidential Information

I, _____, authorize
(Print your full name above)

Name:

Phone Number:

Fax Number:

Mailing Address:

to release information in my medical record to:

Ernest Madhavan, MD

Soundview Psychiatric Services, PLLC

14030 NE 24th Street, Suite 104, Bellevue, WA, 98007

Phone (425) 637-3976

Fax (425) 671-0209

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)

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.

(Signature of patient)

(Date signed)