RANDALL DWENGER, MD
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Authorization for Release of Information

Patient Name	
Date of Birth	/ /

Fill out the information of the physician, psychiatrist, therapist, facility, other health care provider or other party whom you are requesting information from, or will be releasing information to:

Other Party			
Address			
City, State, Zip			
Phone	( ) -		

☐ I hereby authorize and give my consent to **Randall Dwenger, MD** to discuss/release the following confidential and private health information:

- ☐ Psychiatric history, diagnoses and treatment;
- ☐ Substance use history, diagnoses and treatment;
- ☐ Medical history, diagnoses and treatment;
- ☐ Other pertinent personal/health information;

with the above named party, in order to facilitate the coordination of my health care.
This consent includes both verbal and written communication by Dr. Dwenger, on my behalf.

☐ I give specific consent to send Comprehensive Psychiatric Evaluation to the above party.

This release also allows the above named party to discuss my pertinent personal health information with Dr. Dwenger.

☐ I also request that a copy of my:

☐ Medical records; ☐ Psychiatric records; ☐ CXR; ☐ EKG; ☐ Laboratory results;

☐ Other: _____ be sent to Randall Dwenger, MD.

I understand that I am not required to give this consent, and that if I refuse I will be offered psychiatric services, but the potential effect upon the provision of my mental health care will be discussed with me.

This authorization to release confidential information may be revoked by me, in writing at any time, except to the extent that action has already been taken. It shall be effective only long enough to answer the purpose for which it is given, and no further confidential information will be released without the execution of an additional written statement of my consent.

This document authorizes the above named parties to release the information listed for the purposes described. The recipients of the confidential information are legally obligated to maintain the information confidential and are restricted from re-disclosure without further written consent from me unless otherwise permitted under law.

Date of Consent		Signature	
Parent/Guardian Signature (if patient less than 18)			
Date of Expiration of Consent		Witness	