Alice W. Lee, MD, ABIHM

CONSENT FOR RELEASE OF INFORMATION

Patient Print Name: _____

Date of Birth: _____

Today's Date: _____

I hereby authorize (Print name of family member, provider, or therapist):

1.
2.
3.
4.

Located at (relevant addresses or emails):

1.
2.
3.
4.

To release information from the records of (Name of patient):

The information is to be released to Alice W. Lee, MD or (Name of clinician):

_____ for the purpose of facilitating treatment.

The nature of the information allowed to be released is/are:

40 SAINT GEORGE AVE., STAMFORD, CT 06905
PHONE: 301-802-4474• FAX: 801-492-5080
EMAIL: ALICEWLEEMD@GMAIL.COM

Check the following:

___ Verbal Exchange of Information

___ Progress Notes

___ Psychiatric Evaluation

___ Psychological Evaluation

___ Treatment Summary

___ Discharge Summary

___ School Records

___ Other: _____

I understand that I may revoke my consent to release information at any time, except to the extent that the action will have been taken on information prior to the revocation of my consent. Otherwise, this consent is valid from the date of signature.

_____ Date: _____
Patient Name Print/Signature:

_____ Date: _____
Guardian Name Print/Signature:

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