David Sasso, MD, MPH
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– Consent to Release and/or Obtain Information –

Re: _____ _____
(patient name) (date of birth)

I hereby authorize my (or my child's) physician and the Elm City Therapeutic Center to release and/or obtain the information documented below, as applicable.

- ❑ Admission summary or intake
- ❑ Discharge summary
- ❑ Summary of treatment
- ❑ Psychosocial assessment
- ❑ Psychological testing
- ❑ Psychiatric evaluation/medication
- ❑ School reports
- ❑ Medical reports
- ❑ HIV information
- ❑ Alcohol and/or drug information
- ❑ Billing information
- ❑ Other _____

The information noted above will be _____ sent to and/or _____ obtained from:

Name: _____

Address: _____

_____

Telephone: _____ Fax: _____

I understand that the federal and state confidentiality statutes protect my personal health information. This material shall not be transmitted to anyone without my written consent or other authorization as provided by the aforementioned statutes. I also understand that I may revoke this consent at any time, except to the extent that action has been already taken, and that this consent expires automatically one year from the date of signature unless otherwise indicated. The information to be obtained or disclosed was fully explained to me, and consent is given of my own free will. I understand the medical record or clinical information to be released may contain information pertaining to psychiatric and drug and/or alcohol diagnoses and treatment and may also contain confidential HIV/AIDS-related information.

Patient signature: _____ Date of signature: _____

(if applicable)
Parent/guardian: _____ Date of signature: _____

(if applicable)
Parent/guardian: _____ Date of signature: _____