CPS

COMPREHENSIVE PSYCHIATRIC SERVICES
A Medical Group

RELEASE OF INFORMATION

I, _____, authorize and request the following information regarding

_____ to be released _____ , exchanged _____. (Check one)
(Patient's name)

From:	**To:**
Clinician: _____	Name:_____
Comprehensive Psychiatric Services	Address:_____
	_____
	Phone#: _____
	Fax#:_____

From:	**To:**
Name:_____	Clinician: _____
Address:_____	Comprehensive Psychiatric Services
_____	
Phone#:_____	
Fax#:_____	

Information relevant to the following is specifically requested:

- o Evaluations
- o Psychological Testing Results
- o Medical Records
- o Other: _____
- o Treatment Plans
- o Progress Notes
- o Discharge Summaries

This release shall be effective from _____ to _____

_____ _____
Signature of Patient Date of Birth Date

_____ _____
Other Signature when required by Law Date