

# 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)

<b>From:</b> Clinician: _____ Comprehensive Psychiatric Services	<b>To:</b> Name: _____ Address: _____ _____ Phone#: _____ Fax#: _____
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<b>From:</b> Name: _____ Address: _____ _____ Phone#: _____ Fax#: _____	<b>To:</b> Clinician: _____ Comprehensive Psychiatric Services
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Information relevant to the following is specifically requested:

- Evaluations
- Psychological Testing Results
- Medical Records
- Other: \_\_\_\_\_
- Treatment Plans
- Progress Notes
- Discharge Summaries

This release shall be effective from \_\_\_\_\_ to \_\_\_\_\_

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Date

\_\_\_\_\_  
Other Signature when required by Law

\_\_\_\_\_  
Date