

Stacy Greeter, MD

Board Certified in Child, Adolescent, and Adult Psychiatry

2415 University Pkwy, Suite 219
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phone: (941) 4130834
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Authorization for the Release of Confidential Information

I, _____ DOB: _____, authorize Stacy Greeter, MD
(patient name)
to _____ (send) and _____ (receive) information to and from the following agencies or people:

(Name) (Address) (Phone) (Fax)

(Name) (Address) (Phone) (Fax)

(Name) (Address) (Phone) (Fax)

(Name) (Address) (Phone) (Fax)

The type of information to be disclosed can include (check as needed):

Evaluation _____ Psychological/Medical Test Results _____ Medical History _____
Diagnosis _____ Psychological/Psychiatric Reports _____ Social History _____
Treatment Plan _____ Alcohol and Substance Use History _____ **Entire Record** _____

The above information will be disclosed for the purpose of (check as needed):

Planning Appropriate Treatment _____
Continuing Appropriate Treatment _____
Collaboration Between Treatment Providers _____

Exceptions: _____

I understand that I may revoke this consent at any time providing written notice, and after one year this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that this authorization does not extend to the release of HIV/AIDS information unless I have placed my initials here _____. I understand that this authorization does not extend to the release of substance abuse information unless I have placed my initials here _____.

Signature of Patient _____ Date _____

Signature of Parent _____ Date _____

Signature of Witness _____ Date _____

(If patient is unable to sign.)

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**Authorization for Family, Friends, or Advisors to Receive Information
About Your Appointments or The *Status* of Your Bill**

I authorize the only following individual(s) to receive written and/or oral communications about my appointments and the status of my bill.

Authorized Individual(s). Please print name(s)

_____	_____
_____	_____
_____	_____
_____	_____

Signature

Print Name

Date