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AUTHORIZATION TO RELEASE PATIENT RECORDS

I, the undersigned, hereby request and authorize information and records, as described below, to be released (to ☐ / from ☐):

Person/Organization Releasing and/or Receiving Information

(to ☐ / from ☐): **ALAN J. DRUCKER, MD**

I understand that the medical records and information to be released may contain information pertaining to mental health, drug and/or alcohol related treatment, personal and family information, and delinquent and/or adult criminal history. Additionally, results from psychological and neuropsychological testing may also be released. It may also contain related medical information, including test results from medical laboratories.

The disclosure of record sand information authorized herein is required for the purpose of treatment and/or completing a comprehensive evaluation, and/or the coordination of treatment between medical/mental health providers.

I specifically request and authorize information pertaining to the following records be released:

- History and Physical Examination(s)
- Mental Health Evaluation(s)
- Consultation Reports
- Psychological Testing Results
- Neuropsychological Testing Results
- Discharge Summary
- Laboratory Reports
- HIV/AIDS Related Diagnosis/Treatment
- Progress Notes
- Physician Orders
- Medication Administration Records
- School Records (Grades, State Tests, etc.)
- Confidential School Records (IEP's, etc.)
- Radiology and EEG Reports
- Alcohol/Drug Abuse Treatment
- Verbal Exchanges

This authorization is subject to revocation by the undersigned at anytime except to the extent that action based on my authorization has already been taken. If not earlier revoked, it shall terminate twelve (12) months from the date of authorization without express revocation. I understand that revocation must be in writing. A copy of this authorization/request is to be considered as valid as the original.

I acknowledge that I have been advised of what information will be disclosed and understand the benefits and disadvantages of such disclosure. This authorization is given freely and I have not been threatened with discontinuation or refusal of services if I do not sign this form.

I agree that above persons/organizations may Fax the above records.

XXX-XX-

Name of Patient (Printed) Patient's Birthday Social Security Number (Last 4 Only)

Signature Date Signed