STACY GREETER, MD

Release of 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:

Evaluation _____ Psychological/Medical Test Results _____
Diagnosis _____ Psychological/Psychiatric Reports _____
Treatment Plan _____ Entire Record _____

The above information will be disclosed for the purpose of:

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, it's purpose, and who will receive the information. I understand that this authorization does not extend to the release of AIDS/HIV 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.)