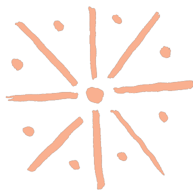

Path to Awareness
Chad Brown, MD
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Pediatric and Adult Psychiatry
809 E Jackson St. Medford, Oregon 97504
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CONSENT TO RELEASE
PSYCHIATRIC / MEDICAL and/or ALCOHOL / DRUG ABUSE
RECORDS

I, ________________________________, BIRTH DATE ____/____/____,
hereby authorize Path to Awareness, PC, to have bilateral exchange of information that is contained in my medical record with: ____.
Under the conditions listed below:

Please Initial All That Apply:

1. This information will be limited to:
   - ____ Psychiatric/medical/alcohol/drug abuse evaluation.
   - ____ Psychiatric/medical/alcohol/drug abuse discharge summary.
   - ____ Progress notes.
   - ____ Psychotherapy notes.
   - ____ Lab studies.
   - ____ Medical tests/studies.
   - ____Psychological testing.
   - ____Educational testing.
   - ____Prescription History
   - ____Other:

2. ____ Purpose or need for such disclosure for continuing care/treatment.

3. This consent is subject to revocation at any time except to the extent that action has been taken in reliance thereon. If not previously revoked, this consent will terminate upon

   ____ As long as I am in their care.
   ____ Other:

4. ____ An additional consent must be obtained for any other transfer or disclosure of this information.

5. ____ I understand that I may receive a copy of this release.

________________________________ ________________
Patient's Signature Date

________________________________ ________________
Parent, Guardian or other Person signature authorized by law to sign in lieu of Patient (where required). Indicate which. Date

________________________________ ________________
Witness Signature (if applicable) Date