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CONSENT TO RELEASE OF INFORMATION

I, _____, Birth Date ____/____/____, hereby authorize Dr. Igor Epstein to have bilateral exchange of information that is contained in my medical record with

_____
_____ .

This information may include psychiatric and medical records such as, but not limited to, psychiatric, medical, alcohol/drug abuse evaluations, discharge summaries, progress notes, psychological testing, laboratory, radiological, or other diagnostic studies.

This information is to be used strictly for the purpose of treatment planning and coordination.

If not previously revoked, this consent will terminate upon
_____.
(Specific Date, Event or Condition)

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

_____ _____
Patient's Signature Date

_____ _____
Witness (if applicable) Date