RELEASE OF INFORMATION

_____ _____/_____/_____
Patient Name Date of Birth

- I hereby authorize the RELEASE OF **INFORMATION FROM** the records at:

Martha J. Little, M.D., D. Ph.
312 Maxwell Road, Suite 200
Alpharetta, GA 30009
Office: (770) 772-0909 Fax: (770) 442-1542

- The information is to be **RELEASED TO:**

_____

_____

_____

_____

- The information to be released includes:

____ Social History
____ Developmental History
____ Medical History and/or Physical Exam
____ Course of Treatment
____ Psychiatric Evaluation
____ Summary of Hospitalization(s)
____ Lab Reports
____ Neurological Examination(s)
____ Medication(s)
____ Teachers' Observations
____ Discharge Summary
____ Treatment Recommendations
____ Psychological Testing
____ Drug and Alcohol abuse treatment info
____ HIV/AIDS Information
____ Other (Specify):
_____

- The purpose for the release of information is:

a) Coordination of treatment b) Continuation of treatment

- This release shall expire in 5 years, *unless otherwise specified*:

(This release may be revoked at an earlier time by written request received from you.)

_____ _____
Signature of Patient Date

_____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of Witness Date