

# 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