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.
814 Mimosa Blvd., Building C
Roswell, GA 30075
Office: (770) 772-0909 Fax: (770) 442-1542

➢ The information is to be RELEASED TO:

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➢ 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