RIDGLEA FAMILY GUIDANCE

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AUTHORIZATION FOR RELEASE AND/OR RECEIPT OF INFORMATION

_____

Patient Name Complete Address Date of Birth

Authorizes Anthony T. Machi, M.D., to disclose or obtain the following information:

_____ Psychiatric Findings
_____ Psychological Findings
_____ Family History
_____ Physical Findings
_____ Progress Reports
_____ Recommendations
_____ Final Diagnosis
_____ Lab Studies
_____ Telephone Conversation
_____ Other (Specify): _____
_____

Verbally or in writing to (please fill in complete name and address):

_____

_____

_____

This authorization is for services that were acquired during evaluation and/or treatment and is for the following purpose:

_____ Continuity of Care

_____ Other (Specify) _____

This authorization shall remain effective unless revoked in writing. I understand that I have the right to revoke this authorization by providing written revocation to the office from which the disclosed information is sent. I also understand that any information which has been disclosed in accordance with this authorization, before it is revoked by me, may be used for the purposes listed. No information is disclosed without the signed consent and authorization of this form. I release the providing facility from all legal responsibilities or liability that may arise from this act.

_____ _____ _____

Patient/Person Authorized to Consent for Patient Date Print Name

_____ _____

Witness Date