RELEASE OF CONFIDENTIAL INFORMATION

PLEASE NOTE: WE ARE UNABLE TO SEND MEDICAL RECORDS UNLESS WE HAVE A <u>SIGNED AND DATED COMPLETED</u> RELEASE FORM. Before November 25, 2020, please complete this form then fax or mail it back to us at**:** The Counseling Center, 621 S. New Ballas Rd., Suite 6018B, St. Louis, MO 63141 **OR** FAX: 314-251-5808. After November 25th, 2020, follow the instructions on our web page: THECOUNSELINGCENTER-STL.COM.

Patient Name:_____DOB:_____

I authorize and request: (**check one please**)

____Eduardo Garcia-Ferrer, MD ____Steven Till, PhD ____Marlon Mangahas, MD

____William Bumberry, PhD ____Brenda McCall, LPC

to release medical records **to:**

_____

(Doctor, psychologist, or institution name)

_____

(**Complete** address, fax number or email address, and phone number of provider named in the previous line.)

( ) I am requesting the facility to copy the following records and send them to the address above.

Information Requested (please initial) ____

I am requesting the following records from my medical record dated __/__/__ to __/__/__:

___Physician progress notes ___Discharge summary

___Psychological notes ___Lab results

___Physician orders ___Treatment plans

Other_____

Other_____

Purpose for which records will be used:_____

<u>This consent for release of confidential information specifically authorized the release of /or drug abuse and/or dependence as provided information regarding alcohol and under Federal Confidentiality Regulations governing confidentiality of alcohol and drug abuse patient records. I also understand I may revoke this consent at any time except to the extent that action has been taken in reliance upon it. This consent expires one year from today or one year after my last day of treatment if treatment continues past today.</u>

_____.

(initial)

I further acknowledge that this consent is given on my own free will.

DATE:_____SIGNED:_____