FAMILY PSYCHIATRY OF THE WOODLANDS

Consent for Confidential Information

I, _____ DOB ____/____/____ authorize Family Psychiatry
Patient's Full Name
of the Woodlands, P.A. at 8701 New Trails Drive, Suite 150, The Woodlands, TX 77381 to release/obtain the following information to/from:

RELEASE TO:

_____
Name

_____
Street Address

_____
City, State & Zip Code

_____
Phone Number

OBTAIN FROM:

_____
Name

_____
Street Address

_____
City, State & Zip Code

_____
Phone Number

____ History/Physical Exam ____ Lab Results ____ Consultations

____ Discharge Summary ____ Dr.'s Orders ____ Progress Notes

____ Psych Reports ____ Verbal Communication ____ ALL RECORDS

For the purpose of: _____

HIV/ AIDS I consent to the release of any positive or negative test results for AIDS or HIV infection with any infection with any other causative agents of AIDS with the rest of my medical records.
Initial: _____ **Date:** _____

I, the undersigned, understand that I may revoke this consent at any time except to the extent that the action has been take in reliance on it and that in any event this consent shall expire in 90 days after the patient is discharged unless another date is specified.

Specification of the date, event, or condition upon which this consent expires: _____

TO THE PARTY RECIEVEING THIS INFORMATION: This information has been disclosed to you from the records whose confidentiality may be protected by federal law. If so, federal law regulations (42CFR, Part 2) prohibits you from making any further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. (FOR PATIENT RECORD APPLICABLE UNDER FEDERAL LAW 42 CFR, PART 2)

_____ _____
Signature of Patient *Date*

_____ _____
Parent/Guardian/Authorized Representative Signature *Date*

_____ _____
Signature of Witness *Date*

December 2013