DAVID LONDON MD

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Authorization to Release or Exchange Information

Patient Information

Client Name [please print]: _____
Address: _____
City, State, Zip: _____
Date of Birth: _____ Phone: _____

Other Party

Name of Person/Organization: _____

Information to be Released

I hereby authorize David London MD to (please initial all that apply)
__ Release Information to __ Gather Information from __Exchange Information with
This information may consist of the following (please initial each line to which consent is given):
_____ Psychological test reports
_____ Psychiatric evaluation reports
_____ Periodic reports of psychotherapy
_____ Alcohol /drug abuse treatment
_____ Social History Data (family, education, employment, arrest, drugs and alcohol)
_____ Medical Information
_____ Communicable Diseases (including HIV and AIDS)
_____ Other (specify):_____

This information will be used (please initial each line to which consent is given):
_____ To determine appropriateness of treatment
_____ To develop a diagnosis and treatment plan
_____ To facilitate coordination of services
_____ At the request of the individual
_____ Other (specify):_____

Acknowledgement

I understand that no information may be forwarded by either party listed in this release to any other individual or agency without my written consent. I understand that this information may not be redisclosed by its recipient. This authorization may be revoked at any time by my written statement except to the extent that authorized persons who are to disclose the information described above have already taken action in reliance on it. It is automatically revoked 30 days after the termination of the therapeutic relationship or under the following conditions:

This consent is given voluntarily, without coercion. Signing this from is not required to receive treatment/services at David London MD.

_____ _____
Client Date Witness Date