Michael D. Smith, Psy.D., P.C.
A Professional Limited Liability Company
Authorization to Request/Release Information:

ATTENTION: In order to enhance continuity of care, it is important for Michael D. Smith, Psy.D., P.C. to share relevant information with other care providers designated by you. Your signature below indicates consent to this process:

*I, _____, born on _____/_____/_____, hereby authorize

MICHAEL D. SMITH, PSY.D., P.C. to obtain information from, AND share information with:

Name: _____

Address**:**_____

_____

_____

*The information that may be requested from or provided to the provider designated above includes:

Psychiatric History Including Diagnosis and Treatment
___Physical Exam; Lab Studies, X-Rays, EKG, EEG
___Drug/Alcohol History and Treatment
___HIV Testing /HIV Related Information
___Other:_____

The specific purpose for which this information is to be released includes:
___Assessment
___Service Planning
___Continuity of Care
___Other:_____

*Exceptions to this release include:_____

I certify that this request has been made voluntarily. I understand that I may revoke the Authorization at any time by written notice to Michael D. Smith, Psy.D., P.C. except to the extent that Michael D. Smith, Psy.D., P.C. has already taken action in reliance on this authorization. Without my express revocation, this Authorization will automatically expire upon satisfaction of the need for disclosure upon termination, or one year from the date of signature.

I hereby release Michael D. Smith, Psy.D., P.C., all attending practitioners, and all employees of Michael D. Smith, Psy.D.,P.C. from all legal responsibility or liability for the release of information listed above from my medical record.

Redisclosure of my medical records by those receiving the above authorized information may not occur without further written authorization and is protected by Federal Law. I also understand that this information may be included in any release as indicated above unless otherwise specified.

A copy of this authorization is as valid as the original.

_____ _____
Client Signature Date

_____
_____
Signature of Parent or Legal Guardian Witness

_____
Relationship of Parent or Guardian to Client