AUTHORIZATION FOR RELEASE OF MENTAL HEALTH INFORMATION

I,____Birthday:_____/______/_______ , hereby authorize:

Faizi Ahmed, MD/ Tampa Neuropsychiatry
603 South Boulevard Tampa Fl 33606
P: (813) 995-1775 **F: (813) 642-4877**

to release and to obtain the following information from my mental health or medical records: **history, evaluations, examinations, studies, diagnoses, formulations, and treatments**
to and from the following individual(s)/agent(s):

Name:	Address:
Phone:	Fax:

In authorizing this release of information, I understand it will be used solely for the purpose of:

coordination/determination of care and treatment planning both now and in the future.

I understand that I have a right to meet with my clinician to inspect my record of mental health information. I further understand that this information cannot be re-disclosed without my expressed authorization and that the law requires this notice:

This authorization releases Dr. Ahmed / Tampa Neuropsychiatry from any and all legal liability that may arise as a result of his compliance with my request. This consent is subject to revocation at any time except that action has been taken in reliance thereon.

My signature below attests to the fact that I have read this form, understand its content and request that the above information be released as specified.

Signature_____________________________________ Date___________________________________