Patient Name_____ Date_____

CONSENT TO RELEASE/RECEIVE INFORMATION

Release to Communicate with Other Providers

I hereby grant my provider (Dr. Suruchi Chandra) to release and/or receive information from the following providers for myself or my child, including diagnosis, treatment options and plans for the health services I receive from this clinic.

Speciality	Name	Address	Phone	FAX
Psychotherapist				
Primary Care				

Release to Communicate with Family Members or Friends

All patients who are 18 or older must sign a release if they would like us to communicate with family members.

I hereby grant my provider (Dr. Suruchi Chandra) to release and/or receive information from the following family members or friends for myself or my child including diagnosis, treatment options and plans for the health services I receive from this clinic.

Name

Name	Relationship	Phone	Email

This consent is valid until such time as I provide this consent written revocation of it.

_____ _____

SIGNATURE (Patient, or Parent/Guardian 1 of Minor) **PRINT FULL NAME** **RELATIONSHIP**

_____ _____

SIGNATURE (Parent/Guardian 2 of Minor) (OPTIONAL) **PRINT FULL NAME** **RELATIONSHIP**