Community and Long-Term Care Psychiatry, LLC

10004 Kennerly Road Suite 362-B
Saint Louis, MO 63128

Phone: 314-525-5050 Fax:314-525-5072

AUTHORIZATION TO RELEASE INFORMATION

Person(s) and/or Organization

Address Phone Number

City, State, Zip Fax Number

Patient Name: _____

Date of Birth: _____

Social Security#: _____

I hereby authorize Community and Long-Term Care Psychiatry, LLC to receive medical records, reports, labs or X rays pertaining to me and to release and/or receive full information regarding my condition including etiology, diagnosis or prognosis.

I also authorize Community and Long-Term Care Psychiatry, LLC to receive any medical records, reports or any information pertaining to previous treatments of alcohol abuse and/or treatment of substance abuse, any psychiatric records or reports, and any information regarding treatment for AIDS or STD's. This authorization will remain valid for the course of treatment unless otherwise stated. A photographic copy of this authorization shall be valid as the original. It is understood that the person authorizing the release and/or to receive this specific information has the right to inspect and copy the information to be disclosed and that this information will not be re-disclosed without proper authorization.

Patient Signature/ Legal Guardian Signature Date