Andrea M. Jimenez, M.D.
Child, Adolescent, and Adult Psychiatry

Authorization for the Release of Information

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Chapel Hill, North Carolina 27517

amjimenezmd@gmail.com
(tel): 919-960-3003(fax): 919-960-3135

Patient Name **Date of Birth**

Address **Phone**

Parent or Legal Guardian:

This form, when completed and signed by you, authorizes Andrea M. Jimenez, M.D. to share protected information from you or your child's clinical record by:

□ Release of information to: □ Exchanging information with: □ Requesting information from:

Name of Person(s) or Agency(s); Address; Phone and/or fax number:

1._____

_____

2._____

_____

3._____

_____

4._____

_____

This information will include:

□ Copies of progress notes
□ Treatment plan and summary (written and verbal)
□ All of the Above
□ Testing/lab results
□ Other (Specify):

This authorization shall remain in effect for: □ 1 year, □ ending _____/_____/_____, □ until the end of treatment

I understand that I have no obligation to disclose the above information and that I may revoke this consent at any time by notifying this office in writing at the address below. Such revocation will not extend to prior release of information on the basis of this authorization. I further understand that this office has no control over information once it has been released and in consideration of this consent, I release Dr. Andrea M. Jimenez from any and all liability arising therefrom.

_____

Signature of Patient Date

_____

Print Name Date of Birth

_____

Signature of Parent or Legal Guardian Date