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Consent to Release Protected Health Information

Please complete this release of information form in order to grant me permission to discuss your case with individuals identified by you for any reason that we have discussed. Please let me know separately if you would like any specific information withheld from such discussions. Please only include ONE party per form. Fill out separate authorization forms for each additional party. Parties may include your previous psychiatrist or psychotherapist, primary medical doctor, a family member, caseworker, attorney, etc.

I, ____, authorize Dr. Justin Capote to discuss and share confidential information about my treatment with the party listed below, and vice versa. This confidential information includes, but is not limited to, my history of psychotherapy and psychotropic medication use, my medical and family histories, my history of drug and alcohol use, my legal and financial status, the results of diagnostic testing, my clinical progress and planned or possible treatment interventions, and any other information deemed important by Dr. Capote to assist with my treatment and/or other personal or business matters requested including, but not limited to, insurance reimbursement, legal action, regulatory action, marital conflict, or child custody. Please include the full name and contact information for the party identified below.

Name of party being authorized: ______________________________________

Preferred method of contact: ____

I acknowledge that this consent can be revoked by me in writing at any time, and that I can do so for any reason except to the extent that: 1. This authorization is deemed necessary to protect my personal safety and/or the safety of others who may be seriously affected by my behavior; 2. Disclosure has already occurred; 3. Any pending action that relies on this disclosure has already been taken and/or is in progress.

Patient Signature: _________________________ Date: _________________