David Kan, M.D.
ADDICTION, FORENSIC & GENERAL PSYCHIATRY

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CONSENT FOR RELEASE AND EXCHANGE OF INFORMATION

Patient Name _____ Date of Birth _____

I hereby Authorize David Kan, M.D. AND:

Name of Person/Agency _____

Address _____

Phone Number _____

Fax Number _____

To exchange information or records obtained in the course of my diagnosis and treatment for psychiatric, alcohol abuse and/or drug abuse care for the purpose of further treatment. This information may also include records and reports concerning Human Immunodeficiency Virus (HIV). Discloser will not be limited unless specified here by me to the following types of information:

_____

I understand that these records are protected under the state/federal confidentiality regulations and cannot be disclosed without my written consent unless otherwise provided for in the regualtions. I recognize that if I am disclosing my health information to someone who is not legally required to keep it confidential, it may be redisclosed and may no longer be protected.

This consent shall be valid until termination of treatment with David Kan, M.D. unless otherwise specified:

_____

My Rights: I do not have to sign this authorization. I may revoke this consent at any time in writing. This would not affect any disclosures already made. I am entitled to receive a cop of this consent upon my request.

_____ _____
Patient Signature Date

_____
Patient Name Printed