RELEASE OF INFORMATION

I, _____, HEREBY AUTHORIZE THE FOLLOWING
(NAME)
INDIVIDUALS AND INSTITUTIONS TO RELEASE INFORMATION, VERBAL AND WRITTEN, **TO** DR. OTT AND TO OBTAIN

INFORMATION (VERBAL/WRITTEN) **FROM** DR. OTT PERTAINING TO _____'S
(PATIENT'S/SON'S/DAUGHTER'S NAME)
ASSESSMENT AND TREATMENT.

NAME/TITLE:_____

ADDRESS/TELEPHONE:_____

NAME/TITLE:_____

ADDRESS/TELEPHONE:_____

NAME/TITLE:_____

ADDRESS/TELEPHONE:_____

NAME/TITLE:_____

ADDRESS/TELEPHONE:_____

I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION AT ANY TIME AND THAT CANCELLATION OR MODIFICATION OF THIS AUTHORIZATION MUST BE PROVIDED BY ME IN WRITING AND RECEIVED BY DR OTT TO BE EFFECTIVE. I UNDERSTAND THAT ANY USE OR DISCLOSURE MADE PRIOR TO THE REVOCATION OF THIS AUTHORIZATION WILL NOT BE AFFECTED BY THE REVOCATION. THIS AUTHORIZATION IS EFFECTIVE IMMEDIATELY AND SHALL REMAIN IN EFFECT FOR 2 YEARS FROM DATE OF SIGNING UNLESS EXPLICITLY REVOKED IN WRITING.

_____ _____

GUARDIAN'S OR RESPONSIBLE PARTY'S SIGNATURE PATIENT'S SIGNATURE IF DIFFERENT

DATE:_____/_____/_____ DATE:_____/_____/_____

010914

DEREK OTT, M.D.
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