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RELEASE OF INFORMATION

I hereby authorize Steven Dworetsky, MD to:

RELEASE: Verbal information · My psychiatric records

Alcohol or drug abuse treatment · AIDS information

TO:

Name_____

Address _____

_____

Telephone_____

OBTAIN: Verbal information · Records of previous medical and/or psychiatric treatment

FROM:

Name_____

Address _____

_____

Telephone_____

· A copy of this release is to be accepted as an original
· Unless stated otherwise, this release will expire in 180 days

NAME_____ SIGNED_____

Today's Date_____ Date of Birth _____

Social Security Number_____