Michael S. Conley, M.D., P.C.

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CONSENT TO RELEASE/RECEIVE OF CONFIDENTIAL HEALTH INFORMATION

I, ______________________________, voluntarily consent to authorize my health care provider(s):
PLEASE PRINT NAME

□ **Michael S. Conley, M.D.**

□ **Sheridan Gordon, M.Ed, LPC**

to use or disclose my health information during the term of this Authorization to the following physician, therapy or individual:

Name: ______________________________

Phone Number: ______________________ **Fax Number:** ______________________

Relationship to Patient: ______________________________

Address: ______________________________

I authorize the release of the following health information:

- □ ***All*** my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.
- □ Only the following records or type(s) of health information:

______________________________.

I understand that I may withdraw this consent at any time, either verbally or in writing except to the extent that action has been taken in reliance on it. This consent will last while I am being treated for my condition by Dr. Michael S. Conley, unless I withdraw my consent, and it will expire 365 days after I complete my treatment.

I understand the records to be released may contain information pertaining to psychiatric treatment, and/or treatment for alcohol or drug dependence. These records may also contain confidential information about communicable diseases including HIV (AIDS) or related illnesses.

I understand that these records are protected by the Code of Federal Regulations Title 43 Part 3 (42CRF Part 2) which prohibits the receipt of the records from making any further disclosures to third parties with the express written consent of the patient

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Patient, Parent or Legal Guardian's Signature Date