Raymond D. Hearey, M.D.

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AUTHORIZATION FOR RELEASE OF INFORMATION

Individual, school, or agency
(make copy for each place or provider)

I authorize Raymond D. Hearey, M.D. and:

Individual, School, or Agency name:

_____

Address: _____

_____

Phone: _____ Fax: _____

To exchange information about:

Patient's name: _____Birth date: _____

This information includes, but is not limited to, medical records, lab results, psychological testing, medication history, and school reports. This information is to be used solely for the purpose of evaluation, diagnosis, treatment, preparing court report, or other: _____. This authorization has the following exceptions: _____

This authorization is valid until patient revokes it.

_____
Signature (patient) Date

_____
Signature (guardian, if necessary) Date

_____
Signature (guardian, if necessary) Date