RAYMOND D. HEAREY, M.D.

8 ORINDA WAY
ORINDA, CA 94563
(925) 317-3378 TEL (925) 317-3381 FAX

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient's Physician
(make copy for each one if needed)

Physician's Name: _____

Address: _____

_____

Phone: _____ Fax: _____

Patient's name: _____Birth date: _____

The above patient is being seen by Raymond D. Hearey, M.D. for psychiatric evaluation and possible treatment.

I give permission for:

_____an exchange of information between you and Raymond D. Hearey, M.D.

_____release of records to Raymond D. Hearey, M.D. Please send medical records to Dr. Hearey at the office address above. Please include the most recent history and physical, labs (e.g. CBC, chemistries, TSH, urine drug screen, lead level), head imaging, and EEG (if any).

Thank you.

Signature (patient) Date

Signature (guardian, if necessary) Date

Signature (guardian, if necessary) Date