Authorization for Release of Information

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize Dr Saurabh Gupta MD I authorize Dr Saurabh Gupta MD

to provide patient information to: to obtain patient information from:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Provider or Facility Name of Provider or Facility

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address Address

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone #/Fax # (Include area code) Phone #/Fax # (Include area code)

TYPE OF RECORDS AUTHORIZED: Psychiatric/Psychological Evaluation and/orTreatment

Drug/Alcohol Evaluation and/orTreatment

SPECIFIC INFORMATION AUTHORIZED: (circle one or more as appropriate)

Assessments Progress Notes Laboratory Test Results Diagnostic Impression

Discharge Summary Treatment Plans Treatment Summary

Other: (please describe)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 My authorization will expire: Upon information transfer or 90 days from this date

Signature of Patient or Representative: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient (if requester is not the Patient): Parent Legal Guardian Other:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dr Saurabh Gupta MD 3411 Silverside Road ,

Ph : Bancroft Building,St 204

Fax: Wilmington,DE 19810Date : \_\_\_/\_\_\_\_/\_\_\_\_

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