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CONSENT FOR EXCHANGE OF MEDICAL INFORMATION

TO: NAME _____
 ADDRESS _____
 CITY _____ STATE _____ ZIP _____

REGARDING: PATIENT'S NAME: _____
 DATE OF BIRTH: _____
 SOCIAL SECURITY #: _____

I hereby give my full permission to the above named person or his employees to exchange verbal and/or written information as listed below:

- | | |
|--|--|
| <input type="checkbox"/> Consultation/Evaluation notes | <input type="checkbox"/> Psychological/Social Assessment |
| <input type="checkbox"/> Outpatient Clinical notes | <input type="checkbox"/> Psychiatric Evaluation |
| <input type="checkbox"/> Birth/Neonatal Records | <input type="checkbox"/> Laboratory Results |
| <input type="checkbox"/> Growth charts | <input type="checkbox"/> Radiology Results |
| <input type="checkbox"/> AIDS/STD Reports | <input type="checkbox"/> Educational Records |
| <input type="checkbox"/> Drug/Alcohol treatment | <input type="checkbox"/> Pertinent Information for Outpatient Planning |
| <input type="checkbox"/> Other _____ | |

I UNDERSTAND THAT THIS AUTHORIZATION, UNLESS SPECIFICALLY LIMITED BY ME IN WRITING BELOW, WILL EXTEND TO ALL ASPECTS OF TREATMENT, AS SPECIFIED ABOVE. FURTHER, I UNDERSTAND THAT THIS AUTHORIZATION, WITHOUT PRIOR REVOCATION WILL EXPIRE ONE YEAR FROM THE DATE OF THE SIGNATURE. EXCEPTION.¹ If patient information is to be released to an employer or financial institution, this authorization is valid for only 90 days from date signed.

 Signature of Patient or Legally Responsible Person

 Relationship to Patient

 Date

¹ RCW 70.02.030