Anita Red, MD
Adult, Adolescent, & Child Psychiatrists

The Office of Dr. Anita Red and Dr. Mustafa Rehmani

**Release of Information (ROI)**

Patient Name: _____
DOB: _____

I authorize the release of my protected health information to:

Name/Organization: _____

Address: _____

Phone: _____

Fax:_____

Email:_____

Purpose of Disclosure

( ) Coordination of care
( ) Legal
( ) School
( ) Insurance
( ) Other: _____

Information to Be Disclosed

( ) Evaluation notes
( ) Medication list
( ) Treatment summary
( ) Entire record
( ) Other: _____

*I understand that this information will be used for my treatment with Anita Red, M.D. I also understand that this release authorizes disclosure information regarding mental health, substance abuse, medical health, social history, and treatment. I also understand that I may revoke consent at any time but that it remains in effect until one year after the date of the signature or the date of discharge of treatment, whichever is later.*

Patient Signature: _____ Date: _____

Witness: _____ Date: _____