

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

**Release of Information (ROI)**

Patient's Name: \_\_\_\_\_

Patient's Date of Birth: \_\_\_\_\_

I hereby authorize the release of my protected health information to:

Name/Organization: \_\_\_\_\_

Address: \_\_\_\_\_

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

Fax: \_\_\_\_\_

Email: \_\_\_\_\_

**Purpose of Disclosure**

- Collaboration of care
- Legal
- School
- Insurance
- Other: \_\_\_\_\_

Information to Be Disclosed: **All health information pertaining to my medical history, mental or physical condition and treatment received.**

*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 (or parent/guardian for minors) Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Office Signature: \_\_\_\_\_ Date: \_\_\_\_\_