Consent to Release Psychiatric, Alcohol or Drug Abuse Patient Records

I, _____, (or parent of_____) DOB: _____
hereby authorize the following person or organization:

Name of Person or Organization _____
Address of Person or Organization _____
Phone _____
Fax _____

To disclose records obtained in the course of treatment for:

- ❑ Mental Health Purposes
- ❑ Alcohol Abuse Purposes
- ❑ Drug Abuse Purposes
- ❑ Other (please specify) _____

Released records/information are to be sent to: Saad A. Shakir, MD, & Associates

- ❑ 2039 Forest Ave, Suite 201, San Jose CA 95128 | TEL 408-358-8090 | FAX 408-358-3940
- ❑ 525 South Drive, Ste. 211, Mountain View, CA 94040 TEL 650-900-8181 | FAX 650-900-8202
- ❑ 595 Buckingham Way, Suite 505, San Francisco, CA 94132 | TEL 415-294-4090 | FAX 415-294-4089
- ❑ 2425 Porter Street, Ste. 11, Soquel, CA 95073 | TEL 831-296-5700 | FAX 831-296-5701
- ❑ 5776 Stoneridge Mall Rd, Ste. 376, Pleasanton, CA 94588 | TEL 925-272-4100 | FAX 925-272-4102

Please release the following information selected from below:

- ❑ All Medical Records or
- ❑ Consultation and Progress Notes
- ❑ Doctor's Orders
- ❑ Laboratory Reports
- ❑ Psychological Testing
- ❑ Other _____

For the following time frame (mo/year): _____ to _____

This consent is subject to revocation by the undersigned except to the extent that action has been taken in reliance hereon, and if not revoked, it shall terminate on _____ (date mm/dd/yyyy) without express revocation.

Patient Signature: _____
Patient Name: _____
Date: _____