Consent to Release Psychiatric, Alcohol or Drug Abuse Patient Records

I, _____, (or parent of _____) hereby authorize Saad A. Shakir, M.D. & Associates/Silicon Valley TMS to disclose records obtained in the course of treatment for:

- ❑ Mental Health Purposes
- ❑ Alcohol Abuse
- ❑ Drug Abuse
- ❑ Other _____

I authorize Saad A. Shakir, MD & Associates/Silicon Valley TMS to release information or records about me to:

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

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: _____