SAAD A. SHAKIR, M.D., F.A.P.A, FACIP AND ASSOCIATES

Integrated Clinical Neurosciences

Diplomate of American Board of Psychiatry and Neurology, Distinguished Fellow of American Psychiatric Association

Adjunct Clinical Associate Professor, Stanford University, School of Medicine

CONSENT TO RELEASE PSYCHIATRIC, ALCOHOL OR DRUG ABUSE PATIENT RECORDS

I, _____, (parent of _____) hereby authorize ***Saad A. Shakir, M.D., Inc.*** to disclose records obtained in the course of my diagnosis and treatment for:

- ☐ Mental Health Purposes
- ☐ Alcohol Abuse
- ☐ Drug Abuse
- ☐ Others

Please Specify

_____

_____

To: (Name and Address of organization to which disclosure is made)

_____

_____

_____

The disclosure of records authorized herein required for the following purpose:

- ☐ Continued Medical Care
- ☐ Other

Please Specify:

_____

- ☐ Legal Counsel
- ☐ Workmans Comp-Ind (For payment)

Such disclosure shall be limited to the following specific types of information:

- ☐ History & Physical
- ☐ Progress Notes
- ☐ Doctors Orders
- ☐ Others

Please Specify:

_____

- ☐ Laboratory Reports
- ☐ Consultations
- ☐ Psychological Testing

These records shall be from my treatment of _____ to _____.

This consent is subject to revocation by the undersigned at anytime except to the extent that action has been taken in reliance hereon, and if not revoked, it shall terminate on _____ (Date, event, or condition) without express revocation.

PATIENT: _____ DATE: _____

Copy received by patient:
☐ Yes ☐ No

_____ Witness

_____ Parent, Guardian, or Authorized Representative of Patient

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