



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

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**CONSENT TO RELEASE PSYCHIATRIC, ALCOHOL OR DRUG ABUSE
PATIENT RECORDS**

I, _____, (parent of _____) hereby authorize

to disclose records obtained in the course of my diagnosis and treatment for:

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

Please Specify

**To: Saad A. Shakir M.D. and Associates Inc.
14651 S. Bascom Ave., Suite 230, Los Gatos, CA 95032
TEL: (408) 358-8090 Fax: (408) 358-3940**

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 _____ without express revocation.
(Date, event, or condition)

PATIENT: _____

DATE: _____

Copy received by patient:

☐ Yes ☐ No

Witness

Parent, Guardian, or Authorized
Representative of Patient

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