GEORGE F. JACKSON III, MD
PSYCHIATRY

Authorization For Release of Information

I, _____DOB: _____

Address: _____ City: _____ State: _____Zip: _____

hereby authorize George F. Jackson III, MD to:

Obtain information from: Release information to: Exchange information with:

Name/Institution/Organization: _____

Address: _____

City: _____ State: _____ Zip:_____

Telephone Number: Area Code: (_____) _____

Email: _____

Type of Information

☐ All Medical Records

☐ Mental Health Records (including evaluations, progress notes and treatment plans)

☐ Other (Please specify): _____

Patient Rights

- The authorization for release of information is active throughout the duration of treatment.
- I understand that I have the right to revoke this authorization at any time by notifying the releasing entity in writing, except to the extent that action has already been taken based on this authorization.
- I understand that the information released is subject to re-disclosure by the recipient and might not be protected by federal privacy regulations.
- I understand that treatment, payment, enrollment, or eligibility for benefits will not by conditioned on whether I sign this authorization.

Signed this_____ day of_____, 20_____

Signature of Patient_____

Legal Representative's Signature_____ Relationship to Patient_____