Nirmal Singh Brar, M.D., Inc.

Diplomate of the American Board of Psychiatry and Neurology

Child, Adolescent & Adult Psychiatry

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AUTHORIZATION TO RELEASE PATIENT RECORDS

I, the undersigned, hereby request and authorize information and records, as described below, to be released [☐ to / ☐ from]:

Person/Organization Releasing or Receiving Information

[☐ to / ☐ from]: **Nirmal S. Brar, M.D.**

I understand that the medical records and information to be released may contain information pertaining to mental health, drug and/or alcohol related treatment, personal and family information, and delinquent and/or adult criminal history. Additionally, results from psychological and neuropsychological testing may also be released. It may also contain related medical information, including test results from medical laboratories.

The disclosure of records and information authorized herein is required for the purpose of treatment and/or completing a comprehensive evaluation.

I specifically request that the following records be released:

- ☐ History and Physical Examination
- ☐ Mental Health Evaluation
- ☐ Consultation Reports
- ☐ Psychological Testing Results
- ☐ Neuropsychological Testing Results
- ☐ Discharge Summary
- ☐ Laboratory Reports
- ☐ HIV Related Diagnosis/Treatment
- ☐ Genetic Testing
- ☐ Progress Notes
- ☐ Physician Orders
- ☐ Medication Administration Records
- ☐ School Records (Grades, State tests, etc.)
- ☐ Confidential School Records (IEP's, etc.)
- ☐ Radiology and EEG Reports
- ☐ Alcohol/Drug Abuse Treatment
- ☐ Other
- ☐ All of the Above

This authorization is subject to revocation by the undersigned at any time except to the extent that action based on my authorization has already been taken. I understand that revocation must be in writing. A copy of this authorization/request is to be as valid as the original.

I acknowledge that I have been advised of what information will be disclosed and understand the benefits and disadvantages of such disclosure. This authorization/consent is given freely and I have not been threatened with discontinuance or refusal of service if I do not sign this form.

I agree that above persons/organizations may Fax the above records.

_____ _____
Name of Patient Patient's Birth Date

_____ _____
Patient's Signature (If Adult) Date Signed

_____ _____
Guardian/Legally Authorized Representative of Patient Date Signed