Sheryl Stefaniak, M.D. FAACAP

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Board Certified
Child & Adolescent Psychiatry

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CONSENT TO RELEASE MEDICAL INFORMATION

Patient Name_____ Date of Birth_____

I,_____,hereby authorize the mutual
(name of patient or representative-please print)

exchange of information between Sheryl H. Stefaniak, M.D. and

_____
Name of hospital, physician, clinic, school, teacher, etc.

_____
Address of hospital, physician, clinic, school, teacher, etc. City, State, Zip Code

_____ _____
Telephone number Fax number

I understand that information to be released for the purpose of psychiatric evaluation and ongoing treatment may include information regarding the following conditioning(s):

-Psychiatric Conditions, Psychological Testing, Progress Notes, Medications Prescribed
-Assessment including Diagnosis
-Treatment Summary, Recommendations, Consultation
-Drug and/or Alcohol Abuse
-Medical Information
-HIV (Human Immunodeficiency Virus)/AIDS(Acquired Immunodeficiency Syndrome)
-Educational Information

I understand that my records are protected under federal regulations, including HIPAA and 42 C.F.R. Part 2, Confidentiality of Alcohol and Drug Abuse Patient records, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that the recipient of this information may, in some circumstances, re-disclose it and then the information may no longer be protected by HIPAA. I may revoke this consent to release medical information at any time by giving written notice to Sheryl H. Stefaniak, M.D. except to the extent that action has already been taken to comply with it. Without such revocation, this consent is valid until treatment with Dr. Stefaniak ends.

I release Sheryl H. Stefaniak M.D. from all legal responsibility and liability for the information released according to the terms of this written consent. If during the course of your treatment you choose to disclose information concerning Human Immune Deficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS), that information may be contained in the records released to the above named individual or agency.

Signature of Patient_____ Date_____
(if 15 years or older)

Signature of Parent or Legal Guardian_____ Date_____

Relationship to Patient_____

Signature of Witness_____ Date_____

A Photocopy or Fax of this Document shall be as effective as the Original