Psychiatry 280, P.C.
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Release of Information

I hereby authorize Samuel Polek, M.D. to release Personal Health Information (PHI) to:

Name: _____
Address: _____
Telephone: _____

The information requested or authorized for release or exchange pertains to:

- ☐ Mental Health
- ☐ Education
- ☐ Drug or alcohol abuse
- ☐ Other:

This authorization is valid for 365 days from the date below or _____, whichever is earlier. I may cancel this authorization by signing, dating, and writing "CANCEL" on this original form or by sending a written, signed and dated request to the doctor above indicating my desire to cancel. I understand that once my information has been released, the recipient might re-disclose it, my doctor has no control over it and privacy laws may no longer protect it. The purpose of this authorization is to improve the quality of my mental health evaluation or treatment.

_____ _____
Patient's Name Date of Birth

_____ _____
Patient's Signature Date

_____ _____
Guardian's Signature (if patient is a minor) Date