Grayson Psychiatry
Child, Adolescent & Young Adult Behavioral Health

Dr. Jillianne Grayson
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Secure E-Fax: 732-605-5910
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RELEASE OF INFORMATION

I _____, hereby authorize Dr. Jillianne Grayson to receive and/or
PARENT/GUARDIAN NAME
disclose information pertaining to the treatment of _____ to/from the following provider:
PATIENT NAME

_____
NAME

_____
ADDRESS

_____
PHONE/FAX

Specifically, I authorize the release of the following information:

O Any applicable medical and/or psychiatric records

O Only records during the period from_____ to _____

O Other: _____

Information is to be used for the purpose of:

O Treatment Care and Coordination

O Other (specify) _____

I understand that authorization shall remain valid from the date of my signature below until treatment ends unless a sooner date is specified here: _____.
DATE AUTHORIZATION EXPIRES

I have been informed that I may revoke this authorization by written or oral communication with Dr. Jillianne Grayson at any time. I certify that this form has been fully explained to me, and that I understand its contents.

_____	_____	_____
ADULT PATIENT OR PARENT/GUARDIAN SIGNATURE	**ADULT PATIENT OR PARENT/GUARDIAN PRINTED NAME**	**DATE**

_____	**JILLIANNE GRAYSON, MD**	_____
DR. JILLIANNE GRAYSON SIGNATURE		**DATE**