Paul P. Roberts, M.D.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____ DOB _____

AUTHORIZE the following physician, hospital, clinic, or other (specify):

Name _____
Address _____
_____
Phone _____ Fax _____

TO RELEASE, for the purpose of patient care, the following information contained in the patient's medical records,

TO: Paul P. Roberts, M.D.
P.O. Box 22110
Seattle, WA 98122
Phone: (206) 382-1555
Fax: (206) 325-9828

[ ] All Records and Reports
[ ] Summary of Medical History and Treatment
[ ] Laboratory Test Reports
[ ] Telephone Contact
[ ] Other (specify) _____

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for alcohol or chemical dependency, reproductive health, sexually transmitted diseases (including HIV/AIDS), or psychiatric disorders/mental illness. Based on the boxes checked below you may release all diagnostic and treatment information and records, including:

[x] Alcohol and/or chemical dependency
[x] Psychiatric disorders/mental illness
[x] Sexually transmitted diseases
[x] Reproductive health

These consents may be revoked at any time except to the extent already relied upon, and, unless earlier revoked by written notice filed with Dr. Roberts, shall expire within 90 days.

Patient Signature _____ Date _____