To: _____

Patient Name _____

Date of birth _____ Soc. Sec. #_____

I request that you send Kenneth Woodrow, M.D. the following information and/or allow him to release information specifically including mental health treatment _____ (initial) and/or services for conditions related to alcohol and/or drug abuse _____ (initial).

The disclosure of records is required for my medical evaluation and treatment. Consent is limited to the following types of information and shall terminate one year ❑ after the date of signature or _____.

I understand that I have a right to receive a copy of this form and that I make revoke this consent in writing at any time, expect with respect to information exchanged prior to such revokation.

1. ____ Diagnosis and evaluation
2. ____ Medications, doses, & durations
3. ____ H&P
4. ____ Consultations
5. ____ Discharge Summary
6. ____ Lab work including: CBC, UA, SMAC-20, thyroid, EEG, EKG
7. ____ Psychological testing
8. ____ Legal information
9. ____ Clinical summary
10. ____ All of the above

Signed: _____

Date: _____