Print Form

Comprehensive Psychiatry Group, Inc.
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Boardman, OH 44512
Phone (330) 884-1900 Fax (330) 884-1928

Consent to Release and Request Information

NAME OF PATIENT: _____ DOB: _____

I understand that it may be necessary to communicate about my treatment at CPG with other parties and that my treating provider can only do so if I complete and sign this release form. I do hereby give my consent to release information to the following parties / obtain information from the following parties for the purpose of evaluation and treatment. Please ✓ the parties below ONLY if you want your provider to contact these parties.

☐ Family Physician: _____
(Name & Address) _____

☐ Pediatrician: _____
(Name & Address) _____

☐ School: _____
(Name & Address) _____

☐ Other: _____
(Name & Address) _____

☐ Psychiatric Evaluation	☐ Treatment Summary	PERMISSIBLE CONTACT
☐ Psychological Testing	☐ Medications	☐ Written
☐ Psychological History	☐ Discharge Summary	☐ Verbal / Phone
☐ School Communication	☐ Treatment Plan	☐ Electronic / Fax
☐ Other _____	☐ Aftercare Planning	☐ Other _____

_____ _____
Patient (or Parent / Guardian) Date

_____ _____
Relationship to Patient Witness

This consent is valid until: _____
(termination of Tx unless otherwise specified)

I understand that I can terminate / revoke this consent at any time. To do so, I must simply check the box below and enter the date. By doing so, all further communication with the above indicated parties will immediately cease.

☐ I hereby revoke this consent / release on this date _____ _____
Name & Relationship to Patient

Federal regulations (42 CFR Part 2) prohibit any further disclosure of these materials without the specific written consent of the patient and or parent / guardian involved. If you feel that you have received this communication in error, please contact the sender immediately.