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Geriatric Psychiatry
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Consent to Release and Request Information

NAME OF PATIENT_____DOB: _____

I understand that it may be necessary to communicate about my treatment with other parties and that Dr. Kaster 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)

☐ Other:
(Name & Address)

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

_____ _____
Patient (or 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 anytime. 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 Part2) 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.