German Corso, M.D. , P.A.

Child and Adolescent Psychiatry
ADHD and behavioral disorders clinic

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Patient's Full Name: _____Date of Birth: _____

_____ is authorized to release information regarding care in the following manner (check 1 or both): ___Verbal Discussion

___Send Copy of Medical Record

Release information for the time period of: _____ to _____OR_____

Information is to be released to: Dr. German Corso, 200 S. 10th St Ste 1301 McAllen, TX, 78501 Ph: (956-803-2111) or FAX: _____

Description of information requested for disclosure:

Purpose of Disclosure:

I understand these records may include drug/alcohol/mental health/communicable disease-related information. I understand that information disclosed could contain reference to results of HIV antibody testing. A photocopy of this authorization should be considered as valid as the original. This consent is subject to revocation by the undersigned at any time, except to the extent that action has been taken in reliance hereon and in any even shall expire within 90 (ninety) days from the date of signature. I understand that disclosure if information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. The information to be disclosed is PRIVILEGED and CONFIDENTIAL and is intended ONLY for the use of the recipient named above.

_____

Signature of Legal Guardian Relationship to Patient Date