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AUTHORIZATION TO RELEASE MEDICAL RECORDS

My signature at the bottom of this form authorizes Joseph Bryer, M.D., to release medical records of psychiatric services he provided to:

Patient Name: _____Date of Birth: _____

THIS INFORMATION SHOULD BE DELIVERED TO:

Name and Title of Recipient: _____

My signature also indicates that Dr. Bryer may convey this information by any means that does so securely, including US Postal Service, Federal Express or similar parcel delivery service, facsimile transmission, secure/encrypted electronic mail, and/or private verbal communication with the recipient.

Recipient Address: _____

Recipient Contact Information, if known: Fax: _____

Email address: _____

Telephone: _____

Printed Name of Patient (or Authorized Representative): _____

Signature of Patient (or Authorized Representative): _____

Date of Signature: _____

This completed form may be returned to Dr. Bryer by any means you wish, including US Postal Service, fax, or other electronic transmission of an image of the completed form.