RELEASE OF INFORMATION

Name:_____ **DOB:**_____

Address:_____

_____

I,_____, hereby authorize Wayne C. Jones, MD, at 375 Municipal Dr. #224 in Richardson, Texas, to release/obtain (please circle) confidential information related to my mental and physical condition to:

_____

_____

_____

Specifically, I wish to have the following information released/obtained:

_____**Psychiatric Evaluations**

_____**History and Physicals**

_____**Discharge Summaries**

_____**Consultations**

_____**Test/Lab results**

_____**Progress Reports**

_____**All Information**

_____**Other**_____

_____

I understand that my medical records, (including mental status information and drug/alcohol abuse) are protected by Federal Regulations. These regulations (42CFR, Part 2) prohibit Wayne Jones, MD from making any further disclosure of my medical information without my specific written consent, and I may terminate this consent at any time by providing written notification. I further waive and release Wayne Jones, MD from any liability resulting in the release/obtaining of the above information.

Signature _____ **Date:**_____

Witness _____