CALLIE EMERY, M.D., P.A.
Child, Adolescent and Adult Psychiatry

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RELEASE OF INFORMATION CONSENT FORM

I, _____, hereby authorize Dr. Callie Emery to disclose records
(Patient or Legal Representative)

and/or exchange information concerning _____ to:
(Client)

PLEASE CHECK

_____ **School:** _____

Contact Person: _____ Phone #: _____

_____ **Medical Doctor:** _____

Address: _____

_____

Phone Number: _____

_____ **Therapist:** _____

Address: _____

_____

Phone Number: _____

_____ **Other:** _____ Phone #: _____

Address: _____

_____

_____ _____
Signature of Patient or Legal Representative Date of Signature

_____ _____
Relationship of Legal Representative Patient's Date of Birth

This consent may be revoked by client in writing at any time.