Jose Calderon-Abbo, MD LLC
3439 Magazine Street, New Orleans, LA 70115
504-891-8808 - FAX 504-891-8883

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____, DOB _____, hereby authorize the release of information regarding my treatment:

FROM: Jose Calderon-Abbo, MD
3439 Magazine Street, New Orleans, LA 70115
PHONE 504-891-8808 - FAX 504-891-8883

TO:
_____
_____
_____

FOR THE PURPOSE OF: Continuation of care

INFORMATION TO BE PROVIDED:
Information regarding psychiatric treatment (including addiction, HIV records):
(check all that apply)
_____ Initial evaluation
_____ Last 2 visits
_____ Medication records
_____ Labs
_____ Diagnosis only
_____ Entire record
_____ Acknowledge attendance only
_____ Other (specify): _____

PLEASE READ THE FOLLOWING AND SIGN BELOW INDICATING YOUR UNDERSTANDING AND AGREEMENT.

I, the undersigned, understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it. This consent will expire upon completion of the transaction and no later than 90 days from the date signed, unless otherwise stated.

_____ _____
Patient or Parent/Guardian Date

_____ _____
Witness Date

TO THE PARTY RECEIVING THIS INFORMATION:
This information has been disclosed from records whose confidentiality is protected by federal law. Federal Regulation (42 CFR Part 2) prohibits you from making any further disclosure without specific written consent of the patient, parent, or legal guardian. A general release of medical information is NOT sufficient for this purpose.