Michael A. Freeman, M.D.
Psychiatry
1036 Sir Francis Drake Blvd.
Kentfield, CA 94904
Phone (415) 378-6678 – Fax (415) 888-3149
Michael.Freeman@marincounty.net

CONSENT FOR RELEASE OF RECORDS AND INFORMATION

___ Michael A. Freeman M.D. is authorized to release and transmit my records to, and discuss my clinical situation with:

___ The party named below is authorized to release and transmit my records to, and discuss my clinical situation with, Michael A Freeman, M.D. Dr. Freeman is authorized to receive my records from, and discuss my clinical situation with:

Name _____

Address: _____

Address:_____

Phone/Fax/email_____

These records and collateral discussions may contain identifying data; past, current, and family psychiatric history; past and current medical and medication history; history of current or past drug and alcohol use; legal, vocational, academic history; mental status exam; laboratory and psychological testing results; diagnostic and treatment information.

This consent also applies to a report summarizing this information, or a telephone review of this information, if applicable.

I consent to the release of the information described above to and/or from the party indicated above.

SIGNATURE _____

Print Name _____

Date _____

Approximate Time Period of Records _____