Michael S. Conley, M.D., P.C.

315 West Ponce de Leon Avenue, Suite 360, Decatur, Georgia 30030

Phone (404) 681-4100 / Fax (404) 681-2300

michaelconleymd.com

CONSENT TO RELEASE AND RECEIVE CONFIDENTIAL INFORMATION

Patient Name: _____

Patient's DOB: _____

I authorize Michael S. Conley, M.D. to:

☐ **Receive my medical history information**

☐ **Release my medical history information**

to the following physician, therapist or individual:

Name: _____

Address: _____

Phone: _____ Fax: _____

I understand that I may withdraw this consent at any time, either verbally or in writing except to the extent that action has been taken in reliance on it. This consent will last while I am being treated for my condition by Dr. Michael S. Conley, unless I withdraw my consent, and it will expire 365 days after I complete my treatment.

I understand the records to be released may contain information pertaining to psychiatric treatment, and/or treatment for alcohol or drug dependence. These records may also contain confidential information about communicable diseases including HIV (AIDS) or related illnesses.

I understand that these records are protected by the Code of Federal Regulations Title 43 Part 3 (42CRF Part 2) which prohibits the receipt of the records from making any further disclosures to third parties with the express written consent of the patient.

_____ _____

Patient's Signature Date

_____ _____

Witness Date