THE HAWKINS GROUP
PSYCHIATRIC CONSULTANTS

2431 East Glenn Ave, Suite 400, Auburn, AL 36830 | P: 334-275-7440| F: 334-218-5815

AUTHORIZATION TO RELEASE/OBTAIN CONFIDENTIAL RECORDS

I, _____ authorize The Hawkins Group to:

_____ release confidential records to:
_____ obtain confidential records from:
_____ exchange confidential records with:

Name: _____
Address: _____
_____
Phone: _____
Fax: _____

The Hawkins Group is requesting to release/obtain the following information:

_____ Physician progress notes
_____ Psychiatric evaluation/medication history
_____ Lab work
_____ Psychological test results
_____ dates of treatment attendance
_____ other (specify) _____

for the purpose of:

_____ evaluation/assessment and/or coordinating treatment efforts
_____ other (specify) _____

This consent will automatically expire one (1) year after the date of my signature as it appears below, or on the following earlier date, condition, or event _____

I understand I have the right to revoke my consent at any time (except to the extent that the information has already been released).

_____
Patient Name (print) Date of Birth

_____
Patient Signature *Date*

_____
Signature of Guardian (if under age 19) *Date*