THE FORT CHRISTIAN PSYCHIATRIC CENTER / SHAW WENDI FORTUCHANG, M.D., P.C.
OFFICE OF
SHAW WENDI FORTUCHANG, MD, FAPA
*ADULT, CHILD & ADOLESCENT AND FORENSIC PSYCHIATRY*
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# CONSENT FOR RELEASE OF INFORMATION

Name: _____ DOB: _____

I, _____, give consent for The Fort Christian Psychiatric Center to receive my protected health information from and release my protected health information to:

Name of person to receive my information: _____

Address: _____

Phone: _____ Fax: _____

The request and authorization applies only to the following information:

_____Medical History/Physical Exam _____Laboratory Test Results _____Consultation Reports

_____Discharge Summary _____Summary of Hospitalizations _____Progress Notes

_____Psychiatric Reports/Tests _____Psychological Reports/Tests _____Teachers' Reports

_____Psychiatric Evaluation _____Medication History _____IEP/504 Plan

_____Treatment Recommendations _____Course of Treatment _____Fasting Labs

_____Other: _____

The purpose of the release of information is: ____Collaboration of Care _____Continuation of Care

The release will expire in 12 months unless specified by you.

I understand that I can cancel this authorization at any time, except for action that has already been taken.

_____ _____
Signature of Patient (18 years and older) Date

_____ _____
Signature of Parent / Guardian Date

*Be joyful in hope, patient in affliction, faithful in prayer. Romans 12:12*