Release of Information:

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I, _____ authorized Adrienne M. Balsam, MD to:

_____ Release records to _____ Obtain records from: _____ Coordinate care with

_____ My physician, Dr. _____

_____ My family member: _____

_____ My lawyer: _____

_____ My therapist: _____

_____ Other: _____

Address: _____

The records include: _____ All information

The purpose for which the records are being released:

_____

This is for treatment dates: _____/_____/_____ to _____/_____/_____ or on-going

I understand this authorization may be revoked by me in writing at any time. I understand I have the right to inspect and copy the information being released.

Signature: _____ Date: _____

Witness: _____Date: _____