Resilience Psychiatric Services, LLC
Hinna E. Shah, MD
901 West Main Street
CentraState Ambulatory Campus
Suite 367 (CN505)
Freehold, NJ 07728

Authorization for Release/ Receive Information

Patient Name:		**DOB:**	
Address:		**Phone:**	

I authorize Dr. Hinna Shah to release/ receive information to/ from:

Name/ Agency:	
Address:	
Phone:	
Fax:	

I authorize to give and receive information concerning my psychiatric/ medical records and treatment to/ from the above-mentioned party. This information is used for the purpose of recommendations/ continued treatment.

I understand that I have the right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing and present a written revocation to Dr. Hinna Shah.

I understand that the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that in the event that I do not sign this authorization, my doctor can still communicate, with any party involved with my treatment, to co-ordinate care in case of any emergencies or potential drug/alcohol abuse.

Patient Signature ______________________ Date ____________

Parent/ Guardian Signature ______________________ Relationship ____________

Witness's Signature ______________________ Date ____________