VALLEY FORGE FAMILY PRACTICE
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Consent to Disclose Confidential Psychiatric, Drug and Alcohol Related Information

I, ____, authorize Dr. Lucy Hornstein, or an authorized representative, to release photocopies of all medical records, charts, notes and any other information relating to my general physical condition, including confidential information related to psychiatric/mental health and/or drug and alcohol diagnosis and/or treatment to:

____

for the purpose of

____and allow him/her or any physicians appointed by him/her to examine this information.

I understand that this consent is subject to revocation at any time except to the extent that Dr. Hornstein or the person/entity making the disclosure has already acted in reliance on it.

This consent will terminate ___________________, unless I revoke it earlier. A photocopy of this instrument may be used instead of the original.

____
SIGNATURE

____
DATE