Fulton Psychological Group

Authorization to Release Information

Patient: _____Date of Birth:_____

Address:_____

I hereby authorize Steven Sager, M.D.. to disclose and/or receive from

_____

(name) (phone #) **(fax)**

information pertaining to my (or my child's) psychiatric services rendered from:

_____ to _____.

Specific information requested includes: _____

_____

This authorization is good until: _____

This authorization allows Dr. Sager to discuss information described above and can be cancelled at any time in writing by the patient.

Signature: _____ Date: _____
(parent, if patient is a minor)

Dr. Sagers' signature: _____ Date: _____

FAX: 818. 591-3041