Fulton Psychological Group

Authorization to Release Information

Patient: ____

Address:____

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

____

(name) (phone #)

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