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Release of information and records request

I give permission to Dr. Kenneth Arfa, MD, and the following individuals or facility, to exchange information about me. This covers psychiatric and medical history, testing, diagnosis, and treatment, and is for the purpose of my psychiatric and medical treatment.

❒ I request that these organizations send the above psychiatric or medical records to Dr. Arfa.

❒ I request that Dr. Arfa send the above records to the following organization or clinician.

Name	Address	Phone/Fax

This release expires one year from today, unless revoked sooner in writing.

✎ _____

Patient signature (or guardian)

✎ _____

Print name

✎ _____

Date signed