Howard Askins, M.D., J.D.
Psychiatry for Adolescents, Adults & Geriatrics
960 East Green Street, Suite 202
Pasadena, CA 91106

Release of Confidential Information Form

Patient:_____

Social Security #:_____

Date of Birth:_____

I authorize:

Name/Agency _____

Address:_____

_____

To Disclose to: Howard Askins, M.D. Phillip D. Snyder, Ph.D.
960 East Green Street, Suite 202
Pasadena, CA. 91106
626-793-7792 626-793-7797 Fax

The release of my personal and confidential records/ information.

Information to be released:_____

Additional separate consents must be obtained for any other releases.

This consent becomes effective _____. This consent can be revoked by the undersigned at any time except to the extent the action has already been taken. If not revoked, this release shall terminate at the end of one year. I understand that I have the right to receive a copy of this document if I so request.

Signed:_____ Date:_____