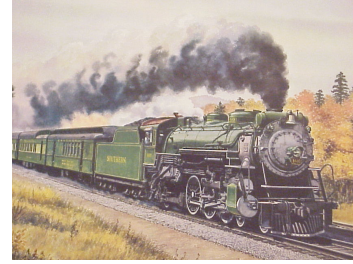


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Fax 303.770.1252



Board Certified in General Psychiatry,
and Child and Adolescent Psychiatry

CONSENT TO RELEASE MEDICAL INFORMATION

Patient Name _____ Date of Birth _____

I, _____, hereby authorize the mutual exchange
(name of patient or representative – please print)

of information between Asa G. Yancey, Jr., M.D. and

Name of hospital, physician, clinic, school, teacher, etc.

Address of hospital, physician, clinic, school, teacher, etc.

City, State, Zip Code

Telephone number Fax number

I understand that information to be released for the purpose of psychiatric evaluation and ongoing treatment may include information regarding the following condition(s):

- Psychiatric Conditions, Psychological Testing, Progress Notes, Medications Prescribed
- Assessment including Diagnosis
- Treatment Summary, Recommendations, Consultation
- Drug and/or Alcohol Abuse
- Medical Information
- HIV (Human Immunodeficiency Virus)/AIDS (Acquired Immunodeficiency Syndrome)
- Educational Information

I understand that I may revoke this consent to release medical information at any time by giving written notice to Asa G. Yancey, Jr., M.D. except to the extent that action has already been taken to comply with it. Without such revocation, this consent is valid until treatment with Dr. Yancey ends.

I release Asa G. Yancey, Jr., M.D. from all legal responsibility and liability for the information released according to the terms of this written consent. I understand that there is the potential for this protected health information to be re-disclosed by the recipient and thus no longer protected under the HIPPA privacy rule.

Signature of Patient _____ Date _____
(if 15 years or older)

Signature of Parent or Legal Guardian _____ Date _____
(if patient under 18 years old)

Relationship to Patient _____

Signature of Witness _____ Date _____

A photocopy or fax of this document shall be as effective as the original