Siyan Clinical Corporation

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Release of Medical Information Form

Patient Name _____ DOB _____

By my signature below, I authorize Siyan Clinical Corporation to release and / or obtain any information from my medical/ psychiatric records including diagnosis, records, examination rendered to me, progress reports, substance abuse/addiction treatment, urine drug screen results, laboratory test results and claims information. This information may be released or obtained to:

Primary Care Physician:	*Phone #:*	*Fax #:*
Address:		
Therapist:	*Phone #:*	*Fax #:*
Address:		
Substance/Addiction Program:	*Phone #:*	*Fax #:*
Address:		
Other:	*Phone #:*	*Fax #:*
Address:		

I understand that my records are protected under the Federal regulation governing **Confidentiality of Alcohol and Drug Abuse Patent Records**, **42 CFR Part 2**, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

This Release of Information will remain in effect until terminated by me in writing.

x_____ _____

Signature of patient or Guardian of minor/ disabled Date