Elaine F. Mateo, M.D.

50 Glenlake Parkway, Suite 425
Sandy Springs, GA 30328
Phone (404) 448-3394 Fax (404) 257-0299

Consent for Release of Information

I hereby authorize: Elaine F. Mateo, M.D.
☐ _____

To:
- ☐ Release information to:
- ☐ Obtain information from:
- ☐ Exchange information with:

Name: _____
Address: _____
_____
_____
Telephone: _____
Fax: _____

The information requested or authorized for release or exchange pertains to:

- ☐ Mental Health
- ☐ Education
- ☐ Drug or alcohol abuse
- ◊ Other _____

This authorization is valid for the duration of treatment. I may cancel this authorization by signing, dating, and writing "CANCEL" on this original form or by sending a written, signed and dated request to the doctor above indicating my desire to cancel. I understand that once my information has been released, the recipient might re-disclose it, my doctor has no control over it and privacy laws may no longer protect it. The purpose of this authorization is to improve the quality of my mental health evaluation or treatment.

_____ _____
Patients Name Date of Birth

_____ _____
Patients Signature Date

_____ _____
Guardian's Signature (if patient is a minor) Date