David Leonard M.D.
3001 Highland Ave Suite E
Cincinnati, Ohio 45219-2315

Phone: 513-961-8861 Fax: 513-487-3770

TWO WAY AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize David Leonard, M.D. and ____

Mailing Address: ____

Phone: _____________________ Fax: ________________________

To release/exchange with each other the following information from my/my child's confidential record regarding treatment.

This authorization includes release of information concerning psychiatric/psychological conditions, medical conditions, drug or alcohol related conditions, HIV testing or AIDS related conditions.

____ Diagnosis ______ Discharge Summary ____Reports of Lab Tests & X-rays

____ Medication ______ Psychiatric Evaluation ____ Initial Assessment

____ Treatment Plan ______ Treatment Progress Notes

____ Other ____

I understand that release of the above information is for the following purpose(s)

____

and will be limited to the above specified items. This consent will automatically expire

____ 90 days after the date signed below

____ 180 days after the date signed below

____ the date of discharge from treatment with David Leonard, M.D.

Unless revoked by me in writing.

I hereby state that I have read and fully understand the above statements as they apply to me. I hereby consent to the disclosure of the treatment records to the purpose and extent stated above.

Please Print

Patient Name: ____ Date: __________________

*Signature: ____ Birth Date: ______________

Relationship to Patient (if other than patient): ____