Erika Marshall, MD
344 Main St., Suite 202A
Mount Kisco, NY 10549
(914) 864-0966

AUTHORIZATION FOR RELEASE OF INFORMATION

I give Erika Marshall MD permission to contact and obtain history and information from the following people/institutions:

Name:	Phone:	Address:
______________________________	____________________	_________________________________
______________________________	____________________	_________________________________
______________________________	____________________	_________________________________
______________________________	____________________	_________________________________

I hereby authorize Erika Marshall MD to ( )release and/or ( ) exchange information with:

Name:	Phone:	Address:
______________________________	______________________	_______________________________
______________________________	______________________	_______________________________
______________________________	______________________	_______________________________
______________________________	______________________	_______________________________

The information requested/authorized for release or exchange includes:
( )Mental health ( )Medical history ( )Sexual history ( ) Drug/alcohol history ( )HIV/AIDS

This authorization is valid for one year from the date of signing this form. I may cancel this authorization by sending a signed and dated letter to Erika Marshall MD indicating that I want to cancel the authorizations. I understand that once my doctor, Erika Marshall MD, releases information she no longer has control over how the person given the information uses it. The purpose of this authorization is to improve the quality of my mental health evaluation and/or treatment.

Signature:_____________________________________ Date:________________________

Printed Name:__________________________________ DOB:_________________________

Relationship to Patient:_________________________________ (self, parent, legal guardian)