Jose Vito MD
Child. Adolescent. Adult and Addiction Psychiatry

RELEASE OF INFORMATION

I hereby authorize, Jose Vito, M.D. to:

☐ Release written or verbal information
☐ Obtain information from
☐ Exchange information with

Name _____
Address _____
City, State, Zip _____
Phone# _____

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

☐ Mental Health
☐ Education
☐ HIV/AIDS
☐ Sexually transmitted diseases
☐ Drug or alcohol abuse
☐ Laboratory Reports

This authorization is valid for 90 days from the date below or whichever is earlier. 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, Dr. Jose Vito has no control over it and privacy laws may no longer protect it. Dr. Jose Vito is not liable to the patient or any other person for any consequences which result from disclosure of patient records. The purpose of this authorization is to improve the quality of my mental health evaluation or treatment.

Print Patient's Name	Date of Birth
Signature of Patient	**Date Signed**

If the patient is a minor or is unable to sign, and a parent or legal guardian or accompanying adult is signing on behalf of the patient, please complete the following information:

(Designated) Parent or Legal Guardian Print Name	Relationship to Patient
Signature of Parent or Legal Guardian	**Date Signed**