

Pearland Psychiatry

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AUTHORIZATION FOR RELEASE OF INFORMATION/RECORDS

I, _____, hereby authorize
Pearland Psychiatry / Dr. Raheem to correspond with _____,
regarding _____ (patient name). I
understand that this correspondence may involve a conversation or transfer of written material.
I further understand that this consent may be withdrawn at any time.

Signature: _____

Date: _____

Relationship to Patient: _____

Witness: _____

Date: _____