NORTH POINTE PSYCHIATRY, PA **ASAD ISLAM, MD**

AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

Primary Care Physician

Doctor's Name: ____

Address: ____

Telephone #: ______________________ Fax #: ______________________

Authorization to contact PCP: (Please circle one) Yes No

Therapist

Name: ____

Address: ____

Telephone #: ______________________ Fax #: ______________________

Authorization to contact Therapist: (Please circle one) Yes No

Pain Management Doctor

Name: ____

Address: ____

Telephone #: ______________________ Fax #: ______________________

Authorization to contact Pain Management Doctor: (Please circle one) Yes No

Other Provider

Name: ____

Type of Practice: ____

Address: ____

Telephone #: ______________________ Fax #: ______________________

Authorization to contact Provider: (Please circle one) Yes No

Patient/Guardian Signature: ______________________ Date: ______________

*Authorization may be revoked at any time by notifying the office. Records are protected under state and federal law.