Adair Look, M.D.
435 Petaluma Ave, Suite 100
Sebastopol, CA 95472
(707) 318-7220

Release of Information

Date:
Name of Patient:
DOB:

I, _____, give my consent to Dr Look to discuss my psychiatric and medical condition with the following family members, care providers and physicians:

1. _____phone number_____
   Relationship to patient_____
2. _____phone number_____
   Relationship to patient_____
3. _____phone number_____
   Relationship to patient_____
4. _____phone number_____
   Relationship to patient_____
5. _____phone number_____
   Relationship to patient_____

I allow communication regarding all records, including, but not limited to: psychiatric history, medical history, legal and financial issues, family matters, medication trials, current medications, drug and alcohol history, other medical treatments and progress of current treatment. I currently request specific communication regarding _____
_____.

This release will be effective for the duration of my psychiatric treatment, but can be revised or revoked at any time. The purpose of this consent is to allow Dr Look to provide the most effective medical care and is only by my request.

Patient's Signature_____Date_____