Release of Information

Janet Lee Kemp MD Ltd
29425 Chagrin Blvd Suite 301
Pepper Pike Ohio 44122
216-292-0610 Phone
216-292-0627 Fax

I, _____(Patient name/legal guardian if minor), Date of Birth _____ hereby authorize Janet Lee Kemp, MD to have bilateral exchange (release information and obtain) of information that is contained in my medical record with:

Name of authorized entity : _____

Address: _____

Phone number: _____ Fax: _____

Under the conditions listed below:

1. This information will be limited to:

____ Psychiatric/medical/alcohol/drug abuse evaluation.
____ Psychiatric/medical/alcohol/drug abuse discharge summary.
____ Progress notes. ____Psychological testing.
____ Psychotherapy notes. ____Educational testing.
____ Lab studies. ____ALL OF THE ABOVE:
____ Medical tests/studies. ____Other:

2. Purpose or need for such disclosure:

_____ Continuing care/ Treatment, and/or _____.

3. This consent is subject to revocation at any time except to the extent that action has been taken in reliance thereon. If not previously revoked, this consent will terminate in 1 year unless otherwise specified:

____ All treatment time period
____ Specified date, event, or condition

Signature of patient (or legal guardian if minor)

_____ Date : _____