LA TMS
Los Angeles TMS Institute

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CONSENT TO RELEASE INFORMATION

I, _____ (print patient's name), hereby authorize Dr. Ian Cook, the Los Angeles TMS Institute, Inc., and the parties identified below to disclose and/or exchange information and/or records regarding my diagnosis, treatment, and other pertinent information. I realize that the exchange of information between the parties named in this document are for the purpose of assisting all involved in properly treating me or facilitating transition of care.

Communication Authorized with:

Name/Title: _____

Address: _____

Phone: _____

Fax: _____

Name/Title: _____

Address: _____

Phone: _____

Fax: _____

Name/Title: _____

Address: _____

Phone: _____

Fax: _____

I understand that my records are protected by federal regulations governing Confidentiality of Patient Records and cannot be disclosed without my written consent except as otherwise provided for in the regulations. I also understand that I may revoke this consent at any time by providing a written request to Dr. Cook.

_____ _____

Signature of Patient, Guardian, or Legal Representative Date