Patient Consent to Release Confidential Information

I, ____________________________________, give permission

Patient Name

to ____________________________________, and my Primary Care Physician,

Psychiatrist or Mental Health Provider

Dr. Stacy Waneka, to share information about my diagnosis and/or treatment related to substance abuse, mental health or medical history. I understand the purpose of sharing information is to help me receive better care.

______________________________________ _________________

Patient Signature Date

This consent can be canceled at any time.