# Daniel S Mundy MD

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Date:_______________________________

I, _________________________________, authorize the individuals and/or institutions named below to release any and all information related to my treatment and medical/ social/ psychiatric history to Dr. Daniel Mundy.

I authorize Dr. Mundy to discuss my treatment with the parties named below for the purpose of facilitating my treatment. I understand that Dr. Mundy will only discuss details of my treatment necessary to my care.

(Please list the parties covered by this release)

| Name | Phone | Fax |
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I understand that I may revoke this authorization by delivering written, signed notice to Dr. Mundy by hand or by certified mail.

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|---|---|---|
| Signature of Patient | Printed Name | Date |
| Signature of Consenting Party<br>(If patient is under 18 years old) | Printed Name | Date |