Françoise Thierfelder
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AUTHORIZATION FOR RELEASE OF (Mental) HEALTH INFORMATION

from Françoise Thierfelder, MD, Child and Adolescent Psychiatrist and Psychotherapist

Re: _____ _____
Patient's Last name, First name Date of Birth (DD/MM/YYYY)

_____ _____
Phone No: Address

I hereby authorize Françoise Thierfelder, MD, Child and Adolescent Psychiatrist and Psychotherapist, to release verbal information to:

_____
Name of Health Care Provider, Institution

_____
Address

_____ _____
Phone No: Fax No:

I hereby waive any and all claims against said Françoise Thierfelder, MD for all purposes whatsoever in connection with the said communication and disclosure of information in the said informative communication.
This information must contain the original signature of the patient, or the legal representative if the patient ist minor or has been declared mentally incompetent provided proof of executorship is supplied.

Signature: _____ Witness Signature: _____

Print Name: _____ Print Name: _____

Date: _____ Relationship to patient:_____
(DD/MM/YYYY)

Date: _____
(DD/MM/YYYY)