935 W. Exchange PKWY, Ste. 110, ALLEN, TX 75013 PH# 972.985.7499 FAX# 972.985.7429

Authorization and Consent to Release Personal Health Information and Medical Records

I, ______________________________, DOB: ________________________

Please Print Full Name

Hereby authorize Eximious Integrated Health Solutions / Premier Psychiatric and Sleep Medicine Associates to:

Release / Obtain

My medical records and my personal health information concerning me

From / To

Recipient's Name and Address:

____

____

____

Phone: __________________ Fax: ____________________

With my signature below, I request Eximious Integrated Health Solutions and Premier Psychiatric and Sleep Medicine Associates to release any and all of my medical records including initial evaluations, all clinic and therapy notes, any interview notes, all labs and personal health information without any restrictions to the above named recipient. I understand that I may revoke this authorization at any time with my written notice.

Signature of Patient: ___________________________________

Date: ______________________