AUTHORIZATION FOR RELEASE OF INFORMATION

TEJPAL SINGH M.D
105 N VIRGINIA AVE, SUITE 207
FALLS CHURCH, VA 22046
703-829-0593 (PHONE)
1-888-959-2142 (FAX)

I, _____ allow VITAL PSYCHIATRY ASSOCIATES staff to exchange information with:

_____
_____
_____

Regarding:

_____
_____
_____

I understand that records and other information will only be disclosed to the extent necessary to assist with treatment and that subsequent disclosure not mentioned herein will not occur except provided by law. This release expires at the end of service.

Consenting person's relationship to named individual:

- ❑ **Self**
- ❑ **Guardian**

Signature of Consenting Person _____ Date: _____