Ilianai Torres-Roca, MD, PA

1304 W Walnut Hill Ln, Suite 100
Irving, TX 75038
Ph: (469)941-0444 Fax: (469) 209-6075

Behavioral Health/Medical Provider Communication Form
(Authorization for Release of Information)

Patient Name:_____ DOB:_____

Address:_____ SS#_____

Home Phone: _____ Mobile:_____

I the undersigned patient or legal guardian (if applicable), hereby authorize verbal and written information to be shared between Ilianai Torres-Roca, M.D. and her Staff and

Name:_____ Relationship:_____

Phone:_____ Fax:_____

Address:_____

Name:_____ Relationship:_____

Phone:_____ Fax:_____

Address:_____

Information to Be Release:

__Medication Record __Progress Notes __Psychiatric Evaluation __H&P/Lab Work

__Psychosocial __Discharge & Aftercare Plan __ Psychological Testing __Treatment Planning

__ Other(Specify)_____

Release of Information for the following purpose: __ Patient Request __ Continuity of Care

I understand that the information shared may include mental health issues/treatment. I understand that this consent does not have an expiration date but I may revoke it in writing at any time.

Signature:_____ Date:_____

Name:_____ Relationship (circle): Self / Legal Guardian

Witness:_____ Date:_____