Sonya Vieira, M.D.
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New York, NY 10001
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Release of Information

I, _____, authorize Dr. Sonya Vieira to release my psychiatric medical information solely to the following person or agency:

_____

Phone Number: _____

I give my consent for Dr. Vieira to communicate directly to the above individual(s) about my case. The information to be disclosed includes the nature and extent of my psychiatric care, both current and past. It is to be used to assess my needs and aid in planning my treatment.

I understand that the information to be release is confidential and protected from disclosure and that I have the right to cancel my permission to release information at any time before it is released.

Name of Patient: _____

Signature of Patient: _____ Date: _____

If minor, Guardian's Signature: _____ Date: _____