Monisha Vasa, M.D.
General and Addiction Psychiatrist

Consent for Use, Disclosure, and Receipt of Mental Health Information

Name : _____

Date of Birth : _____

Dr. Monisha Vasa is authorized to release, request, and exchange information regarding diagnosis and treatment with the following parties. Potential reasons for such exchange would include increasing collateral information to clarify diagnosis and treatment, coordinating care with other medical or healthcare professionals, and/or engaging important sources of support in your treatment.

	Name	Relationship	Phone/fax
1			
2			
3			
4			
5			

Signature of patient/legal representative: _____

Printed name: _____

Date:_____

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