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RECORDS RELEASE AUTHORIZATION

FOR THE RELEASE OF PROTECTED MENTAL HEALTH INFORMATION

Instructions for use: Complete this form if you would like us to be able to disclose protected health information (PHI), i.e. treatment plans, scheduling appointments, prescriptions, medical records requests, etc with a family member, another healthcare provider, or other authorized person. *PLEASE NOTE: If we do not have this release of information on file for a spouse or family member, HIPAA laws prevent us from being allowed to discuss any aspect of your care with them.*

By signing this form, confidential psychological and psychiatric information can be released to and/or discussed with the people or agencies listed below unless noted by exclusions or limitations. This form is signed voluntarily and may be revoked at any time. All disclosures made pursuant to this form are valid as long as they were made before the date of revocation.

Patient Name: _____ Patient Date of Birth: ____ / ____ / _____

I authorize my provider to ☐ RELEASE ☐ RECEIVE psychological/psychiatric mental health information to/from the SECOND PARTY as directed below:

SECOND PARTY

Name: _____

Address: _____

Fax Number: _____ Phone Number: _____

TYPE OF INFORMATION TO BE DISCLOSED

☐ I authorize disclosure of all health information, including information relating to medical, pharmacy, mental health, substance abuse, and psychotherapy

☐ I authorize only the disclosure of the following information: _____

PURPOSE OF DISCLOSURE

☐ My health information is being disclosed at my request or at the request of my personal representative; or

☐ My health information is being disclosed for the following purpose: _____
Note any exclusions or limitations here: _____

I understand that treatment, payment, enrollment in a health plan, or eligibility for benefits is not dependent on my signing this authorization. By signing below, I acknowledge that I have read and understand this document and that I have voluntarily given my provider authorization to disclose my records. I understand that I may revoke this authorization at any time by providing a written notice to my provider, however the revocation will not have an effect on any actions taken prior to the date my revocation is received. I understand that my information may be redisclosed by the authorized person/organization receiving the information, and at that point, the information may no longer be protected under the terms of this agreement. This authorization will expire one year following the date signed unless revoked in writing.

_____ _____
Patient Name *Patient Date of Birth*

_____ _____
Signature *Date*

_____ _____
Responsible Party Name (If other than Patient) *Relationship to Patient*

☐ *Authorization is given on this patient's behalf due to being a minor or unable to sign.*