AUTHORIZATION FOR RELEASE OF PSYCHIATRIC RECORDS (Please Print)

Patient Name: ____ **Date of Birth:** __________________________

Address: ____

____

Daytime Phone Number: ____

I hereby authorize my physician(s) and/or administrative and clinical staff at _____________________________

____

to disclose the protected health information described below to:

Name____

Address____

Mail: ____ Pickup: ___

Paper: ____ Electronic: ____

For your convenience we now generate all requested records in electronic format unless requested otherwise.

Information to be released:

____ All Psychiatric Records
(Psychotherapy, counseling notes will only be released with the originating providers approval.)

____ONLY the Information Described as Follows in accordance with the Federal Refister/vol.65,no250 section 164.508(a)(3)(iv)(a) date first seen to current date seen, current medications, diagnostic impression and plan of care____

____

____

(**NOTE: A fee may be charged for providing your records.**)

This protected health information is to be disclosed for the following purpose:______________________________________

____

I understand that my physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits on whether I provide authorization for a requested disclosure except if health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Privacy Contact of the practice I authorized above to disclose the specified protected health information. I understand that a revocation is not effective to the extent that action has already been taken in reliance on the authorization or during an insurance claim contestability period if my authorization was obtained as a condition of obtaining insurance coverage.

I understand that a photocopy of this authorization shall have the same force and effect as the original authorization.

I understand that information disclosed pursuant to this authorization may be re-disclosed by the recipient and may no longer be protected by federal or state law.

EXPIRATION DATE: This authorization is valid until ________________________, at which time this authorization to disclose this protected health information will expire. If no expiration date is indicated above, I understand that this authorization will be valid for ninety (90) days from the date signed.

____ ____
Signature of Patient/ Legal Representative Date

____
Relationship to Patient