Convenient, Comprehensive Mental Healthcare Tailored to Your Lifestyle.

FOR THE RELEASE OF PROTECTED MEDICAL RECORDS

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. This form does not provide for the release of psychotherapy notes, including notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a counseling session.

Patient's Name: _____ Date of Birth: _____
First Name Last name MM/DD/YYYY

Authorization

□ I authorize my provider to release medical records, including psychological/psychiatric mental health information to the **SECOND PARTY** as directed below:

Name of the facility: _____

Address: _____

Fax Number: _____

Phone Number: _____

Type of Information to be disclosed

I authorize only disclose of the following information:

□ I authorize disclosure of all health information in my medical records, which do not include psychotherapy notes.

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:

_____
_____
_____
_____

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Limitations

Note any exclusions or limitations here:

_____

_____

_____

_____

I understand that: Information from mental health clinical records may only be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person. 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. | 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.

_____

Signature

_____

Date

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

_____

Legal Guardian/ Personal Representative's Signature

_____

Date