Plymouth Psych Group

RELEASE OF INFORMATION FORM

Name: (Last, First, M.I.)	**Date of Birth:**
Address:	**Phone:**

If there are records that would be important for your provider to view (i.e. from a therapist/counselor, primary care provider, school, hospital etc.), please use this form to have them sent to you or faxed to us for your continued care.

Please make a check mark next to "Most recent evaluation + last 3 progress notes" and next to any other applicable information the provider may need before signing at the bottom.

AUTHORIZATION FOR RELEASE AND DISCLOSE OF PATIENT INFORMATION

Choose One:

___I authorize Plymouth Psych Group to **RELEASE** information **TO** the Clinic/Provider/Guardian below

___I authorize Plymouth Psych Group to **OBTAIN** information **FROM** the Clinic/Provider/Guardian below

Clinic/Provider/Guardian:	**Phone**
Address:	**Fax:**

Request for the following information:

☐ Most Recent Diagnostic Assessment + Last 3 progress notes ☐ Dates: From _____ to _____

_____ Medical Records
_____ Progress Notes
_____ Labs/Radiology
_____ Psychological Testing
_____ Contact by Telephone
_____School Records
_____ Evaluations
_____ Medication History
_____ Letter/Documentation
_____ Leave Message

I am requesting this information be released for the following purpose:
____ Coordination of Care ____ Insurance ____ Legal ____ Personal Other: _____

Information will be faxed unless otherwise indicated here: _____

- With the exception of psychotherapy notes, all records pertaining to psychiatric mental health, chemical dependency and/or AIDS/HIV related illness/testing will be released unless otherwise indicated by a checkmark here:_____
- Please indicate any restrictions. (Specify)_____
- I understand I may revoke this authorization by written request at any time to the address listed at the top of this form.
- I understand that the revocation will not apply to the information that has already been released in response to this authorization.
- This authorization will automatically expire one year from the date of my signature, or a lesser period of time if specified here: _____The expiration period noted here may exceed one year only in certain situations as specified by law.
- I understand that once the information is released pursuant to this authorization, Plymouth Psych Group cannot prevent the re-disclosure of the information to another third party.
- I understand this authorization must be filled out completely and signed in order to be considered valid.
- A copy of this authorization is as valid as the original bearing my signature.
- I understand there may be a charge associated with the Release of Information Services rendered. There is no charge for release of information to other health care facilities.

_____ _____ _____

Signature **Parent/Guardian Signature** ***(if 15 or younger)*** **Date**