AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

PATIENT NAME:____DOB:________________

The undersigned patient, parent or legal guardian requests:

SPECIFIC TYPE / EXTENT OF INFORMATION TO BE DISCLOSED:

___All Available Records ___Psychiatric Evaluation ___Progress Notes
___Legal /Attorney Notes ___Lab Results ___Other (as specified)
____

INFORMATION RELEASED:

To:________________________________ From: _________________________________
____________________________________ ____
____________________________________ ____
____________________________________ ____
Ph#______________Fax#_______________ Ph#________________Fax#_________________

Dates to be included: From ______________________________ To________________________________

For the stated purpose or need:____

It has been explained to me the specific type of information requested as well as the benefit and disadvantages of releasing the information, if known. Also, I have been informed that treatment services are not contingent on my decision concerning this release. I have carefully read, and understand the foregoing. I voluntarily consent to the release of the above-specified information about my condition and the diagnosis and psychiatric treatment to those persons or agencies listed above. Furthermore, I release my attending physician, his associates and employees from any liability arising from the release of this information or records to such designated persons or agencies. This consent is subject to revocation, in writing at any time and expires on ____________, or 1 year after the date of signing if not otherwise specified.

Signature:____Date:____________________
Patient / Parent / Legal Guardian

Print Name:____Phone#:__________________

Signature:____Date:____________________
Patient signature, if patient is between 14 and 18 years old

Witness:____Date:____________________

Print Name:____Phone#:__________________

Return by mail or fax to 208-898-8989

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