AUTHORIZATION TO RELEASE MEDICAL/PSYCHIATRIC INFORMATION

DISCLOSURE: I, _____ hereby authorize _____ to release and discuss medical records, (including any information related to medical, surgical, psychological, social, psychiatric, drug and/or alcohol abuse, diagnosis, treatment, prognosis and/or therapy) therein contained. ****Initial:** _____

Please release any information FROM:

_____
(Name)

_____
(Address)

_____
(City) (State) (Zip)

Please release information TO:

_____
(Name)

_____
(Address)

_____
(City) (State) (Zip)

The type of access requested is: ☐ Inspection of the Record ◆ Copies of the Record

*** If you wish to pick up medical records, check here ☐
*** If you wish to have the medical records faxed to # 972-232-7401, check here ◆
*** If you wish to have the medical records mailed to the address above, check here ☐

I specifically need the following information released:

_____ Progress Notes _____ Medication List _____ Labs
_____ Other: _____
_____ Entire Record (reason why): _____

The recipient of the information released may use it only for the following purposes (must be indicated):

_____ Assessment & Evaluation _____ Claims Settlement _____ Personal Use
XXXXXXX Continued Care & Treatment _____ Military _____ Aid Entitlement
_____ Placement & Aftercare _____ Health Insurance Enrollment _____ Employer
_____ Legal Proceedings or Advice _____ School/Educational Needs _____ Verbal Exchange
_____ OTHER: _____

The information authorized for release may include information which may be considered information about communicable or venereal diseases. These may include but are not limited to diseases such as Hepatitis, Syphilis, Gonorrhea, and the Human Immunodeficiency Virus, also known as Acquired Immune Deficiency Syndrome (AIDS). ****Initial:** _____

I understand that my records are protected under the Federal regulations governing Confidentiality of Alcohol & Drug Abuse records (42 CFR, Part 2), and cannot be disclosed without my written consent unless otherwise provided for in the regulations. This consent is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance on it, and unless further limited by a date stated here _____ will expire after a period of 90 days (3 months). I have a right to receive a copy of this authorization upon my request.

DATE	TIME	PATIENT SIGNATURE (IF SIXTEEN YEARS OR OLDER):	
RELATIONSHIP	TIME	RESPONSIBLE PARTY SIGNATURE	
RESPONSIBLE PARTY PHONE NO. - HOME ( )		WORK ( )	CELL ( )
DATE	TIME	WITNESS SIGNATURE	TITLE

INFORMATION RELEASED FROM THE MEDICAL RECORD:

☐ **Progress Notes** ☐ **Medication List** ☐ **Labs**
☐ **Other:** _____

Records copied by: _____ Date sent: _____
Via: ☐ U.S. Mail ☐ Pick-up ☐ Other _____
Records given to: _____
Faxed to phone number: (_____) _____ Attention: _____

PSYMED SOLUTIONS
RELEASE OF INFORMATION REQUEST
4501 JOE RAMSEY BLVD, SUITE 260, GREENVILLE, TX 75401
7170 PRESTON RD, SUITE 200, PLANO, TX 75024
OFFICE 972-232-7474 FAX 972-232-7401

Patient Identification:
Patient Name: _____
D.O.B: _____ **DOS:** _____
SSN: _____