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:

Psymed Solutions
(Name)
7170 Preston Rd, STE 200
(Address)
Plano, Texas 75024
(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:

XXXXXXX Discharge Summary **(if available)**
_____ Physician Orders
XXXXXXX Psychosocial Evaluation
XXXXXXX Labs
XXXXXXX Psychiatric Evaluation
_____ Intake Assessment
XXXXXXX Medication Reconciliation **(Not MAR)**
_____ Entire Record (reason why): _____
_____ History & Physical
_____ Nursing Assessment
XXXXXXX Other: DC Plan

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

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

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:

☐ **Discharge Summary** ☐ **Psychiatric Evaluation** ☐ **History & Physical**
☐ **Medication Records** ☐ **Physician Orders** ☐ **Laboratory Report**
☐ **Intake Assessment** ☐ **Nursing Assessment** ☐ **Entire Record**
☐ **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: _____