Midwest Regional Health Services

YOUR HOME FOR BETTER HEALTH

Behavioral Health Release of Information

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NAME: _____ Birthday: _____

ADDRESS: _____ Contact #: _____

_____ SSN #: _____

I hereby authorize and request exchange of my medical records and Psychotherapy notes between my primary provider and my mental health provider:

Primary Provider: _____

Information to be disclosed:

_____ Discharge Summary	_____ EKG/EEG	_____ CT/MRI/Ultrasound
_____ History & Physical Exam	_____ Echocardiogram	_____ Vascular Study
_____ Operative Report	_____ Holter Monitor	_____ MRA
_____ Pathology Report	_____ Laboratory Results	_____ Emergency Room Records
_____ Clinic Notes	_____ Consult Notes	_____ Psychiatric Information
_____ PT/OT Therapy Notes	_____ X-Ray Notes	

_____ Special x-ray reports (name): _____

_____ Other (Name) _____

Purpose of Release: ____Medical Care and/or Behavioral Health Care

This statement of consent can be revoked at any time before disclosure of the information, and expires, in any event, six months after it is signed. Date of expiration: _____

I understand that I may revoke this authorization at any time before by notifying the providing organization in writing. If I revoke the authorization, it will not have effect on actions taken prior to receipt of this revocation.

I understand that the individual/institution that receives the information described above may not be covered by federal privacy regulations, and that the information may be re-disclosed publicly and no longer be protect by those regulations.

_____ _____
Signature of Patient Signature of Parent/Guardian/Authorized Representative

_____ _____
Date Relationship of personal above to patient