Consent for Release of Health Information – PLEASE PRINT

Patient Name:_____Date of Birth:_____

Address:_____City:_____State:_____Zip:_____

I authorize and request:

Release Records From: **(Please include all information)**	**Send Records to:** **(Please include all information)**
Facility Name/Doctor:	Facility Name/Doctor:
Address:	Address:
Phone:	Phone:
Fax:	Fax:

Dates/Specific Information to be released:

[ ] 2 years prior from last date seen
[ ] Specific Dates:_____
[ ] Entire Chart *fee may apply
[ ] Specific Information:_____
_____

Purpose of disclosure:

[ ] Change of Insurance or Physician
[ ] Continuation of Care/Specialist
[ ] Other:_____
[ ] Establishing Care with new Physician

HIPPA Privacy Statement:

I understand that my medical records are confidential. I understand that by signing this authorization I am allowing the release of my medical information requested to the facility or person specified. Drug, Alcohol and Sexually Transmitted Disease records including HIV (AIDS virus) is specifically protected by federal regulations and by signing this release I am allowing the release of those records unless otherwise written. I understand that my records may contain personal information regarding previous psychiatric treatment plans and specific information that unless I specifically decline and specify in writing will be disclosed upon signing this release. I understand that some records will be re-disclosed from another facility if included in my medical record. I may revoke this authorization at any time by written request from myself or personal legal representative on my behalf. I understand that the revocation will not apply to information that has already been released. Medical Record requests will be at the discretion of the facility when processed.

*This release of information shall remain in effect for 1 year from date of signature below unless revoked earlier by myself. If revoked earlier, it is understood by all parties that any information released prior to being notified of such revocation was made at my request.

*I have read the above and do hereby acknowledge that I fully understand the terms and conditions of this consent.

*I understand that I am responsible for any and all fee's that may apply when requesting medical records.

Date:_____ Patients Signature:_____