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Authorization of Release/Request of Information

Patient Name:_____**Date of Birth:** _____

I authorize (release from):

_____
Hospital/Clinic/School/Doctor/Other

_____
Address/City/State/Zip

_____
Phone Number Fax Number

To Release To:_____
Hospital/Clinic/School/Doctor/Other

_____
Address/City/State/Zip

_____
Phone Number Fax Number

Purpose Of Release: ☐ Continuation of Care ☐ Coordination of Care ☐ Other_____

Check Information to be released:

_____Treatment Plan _____ Discharge Summary _____Psychological/Psychiatric Evaluation _____ Progress Notes

_____Social History _____Chemical History _____Attendance of Counseling _____History and Physical

_____Mental Health Record _____ All Health Information

_____Other_____
Release Method: _____Fax _____Mail _____Verbal _____Email_____

I understand that by signing this form, I am requesting that the health information specified will be sent to the party named. I may stop this consent at any time by writing to the organization/professional named in the above. If the information has already been released based on my request, the request to stop the information will not work for that information. I understand that when I release information, it may be re-disclosed by the third party that receives it and may no longer be protected by federal or state privacy laws. I understand that authorizing the release of this health information is voluntary. I can refuse to sign this authorization. I understand that I may inspect or copy the information to be used or disclosed.

This authorization will end one year from the date the form is signed unless I indicate an earlier date or event here:_____

Signature _____ Date _____
Patient/Parent/Guardian

REV: 01/21