

**AUTHORIZATION FOR RELEASE OF PSYCHIATRIC & MEDICAL INFORMATION**

I, \_\_\_\_\_, do hereby consent and authorize \_\_\_\_\_  
 (Patient Name) (Name of Releasing Facility)

to use and/or disclose my health information to: \_\_\_\_\_  
 (Name of Receiving Facility)

The information relating to my identity, diagnosis, prognosis, and care plan. I understand that the specific type of information to be disclosed includes:

- \_\_\_\_\_ Please send the entire medical record (all information)      \_\_\_\_\_ Aids or HIV Test results if applicable
- \_\_\_\_\_ Colonoscopy/Pathology      \_\_\_\_\_ Clinician office chart notes      \_\_\_\_\_ Transcribed hospital reports
- \_\_\_\_\_ Laboratory reports      \_\_\_\_\_ Medical records needed for continuity of care      \_\_\_\_\_ X ray reports
- \_\_\_\_\_ Hospital notes      \_\_\_\_\_ Consultation notes      \_\_\_\_\_ Diagnostic imaging reports      \_\_\_\_\_ Other

The purpose or need of this disclosure is for further medical evaluation and medical care. All records are confidential and treated as such. Except to the extent that action has already been taken in reliance upon this authorization, I understand that I may revoke this authorization at any time by giving written notice to the practice. Unless revoked earlier, this Authorization will expire 30 days from the date of signing.

**PATIENT DEMOGRAPHICS:**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

\_\_\_\_\_  
 Patient 's Signature or Individual 's Legal Representative /Relationship      Date

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_ (witness signature only)