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PERMISSION TO RELEASE MEDICAL/ PERSONAL INFORMATION

PATIENT NAME: _____ BIRTHDATE:_____

MAILING ADDRESS:_____ Phone Number:_____

I request the release of my records from the following provider:

FROM: _____ mailing address:_____

Phone #:_____ Fax #:_____

I request these records to be sent to the following provider:

TO: _____ mailing address:_____
Phone #:_____ Fax #:_____

Purpose of the release: ☐ continuing medical care ☐ other: _____

Information to be released: ☐ Psychiatric Evaluation ☐ Chart Notes ☐ OTHER INFORMATION (list):

_____

_____**I authorize the disclosure of information concerning drug and /or alcohol use/conditions**.
initial

_____**I authorize the disclosure of information concerning mental health conditions**.
initial

TREATMENT DATES TO BE RELEASED:_____
(Timeframe)

This authorization **expires in 90 days from the date signed unless revoked in writing** prior to 90 days but not retroactive to the release of information made in good faith.

_____ _____
Patient **Signature** **Date**

_____ _____
Parent Signature, if Patient is a minor Date

PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42CFR Part 2) prohibit you from making any further disclosure of this information, except with the specific written consent of the person to whom it pertains. A general authorization for the release of medical or other information if held by another party is not sufficient for this purpose.

January 2013 revised