PSYCHIATRIC MEDICAL RECORDS RELEASE AUTHORIZATION

Patient Information:
Full Name: [Patient Name]
Date of Birth: [MM/DD/YYYY]
Social Security Number (Optional): [XXX-XX-XXXX]
Phone Number: [Phone Number]

Provider Releasing Records:
Facility/Doctor Name: [Name]
Address: [Street, City, State, Zip]
Phone/Fax: [Phone/Fax Number]

Recipient of Records:
Name/Organization: [Name]
Address: [Street, City, State, Zip]
Phone/Fax: [Phone/Fax Number]

Information to be Disclosed:
[ ] Complete Psychiatric Record
[ ] Intake and Evaluation Notes
[ ] Diagnosis and Treatment Plan
[ ] Medication History
[ ] Psychotherapy Notes (Requires specific authorization)
[ ] Lab Results and Testing
[ ] Other: [Specify]

Purpose of Disclosure:
[ ] Personal Use
[ ] Continued Healthcare/Referral
[ ] Legal Proceedings
[ ] Insurance Claim
[ ] Other: [Specify]

Authorization Statements:
I understand that my psychiatric records may contain sensitive information regarding mental health, drug or alcohol treatment, and HIV/AIDS status. I specifically authorize the release of these records. I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken. This authorization will expire one year from the date of signature unless otherwise specified here: [Expiration Date/Event].

Signature:

_____
Patient or Legal Representative Signature

_____

Date Signed

_____

Relationship to Patient (if applicable)