IMPACT PSYCHIATRIC CARE, LLC

Authorization for Use/Disclosure of Information/Release of Information

I hereby authorize the disclosure of information from the medical records of:

Patient Name (full name)	
Date of Birth	
Social Security Number	

Medical record information to be disclosed:

- ☐ **All**
- ☐ **Psychiatric Condition/Assessment**
- ☐ **Coordination of Care**
- ☐ **Consultation/Supervision**
- ☐ **Treatment Planning**
- ☐ **EKG/Labs**
- ☐ **Rehabilitation, development**
- ☐ **Drug/Alcohol Abuse**
- ☐ **HIV/AIDS**
- ☐ **Legal**
- ☐ **Medical Care**
- ☐ **Other: _____**

Disclosure Method:

☐ Release medical records ***from*** Impact Psychiatric Care, LLC ***to***:

Name	
Address	
Phone Number	
Fax Number	

☐ Release medical records ***to*** Impact Psychiatric Care, LLC ***from***:

Name	
Address	
Phone Number	
Fax Number	

AUTHORIZATION: I understand that the disclosure of health information is voluntary. I further understand when medical records information is disclosed, the federal HIPAA Privacy Rule may no longer protect it. This authorization will automatically expire one (1) year from the date of this request or on the following requested date: _____.

_____	_____	_____
Patient Signature	Patient Printed Name	Date
_____	_____	_____
Name of Legal Guardian	Legal Relationship	Date

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