Barry F. Gritz, M.D.

Christine Wysong, APRN, PMHNP, BC Alexis Williams, APRN, PMHNP, BC Simonpeter Emokpaire, DNP, PMHNP, BC
Nicole Price, APRN, PMHNP, BC

Board Certified
Diplomat of the American Board
Of Psychiatry and Neurology

2211 Norfolk St., Ste. 410
Houston, TX 77098
713-869-7400 OFFICE
713-869-7404 FAX
Tax ID # 271577881

NPI#1487635892 BG
NPI# 1821157363 CW
NPI# 1831561901 AW
NPI# 1578106217 SE
NPI#1700397726 NP

Authorization For Release of Information from Medical Records

Patient Name: _____ Birth Date: _____

Date Requested: _____ Expires upon request by patient

I hereby authorize Dr Barry F. Gritz M.D. / Christine Wysong APRN, PMHNP, BC. / Alexis Williams APRN, PMHNP, BC. / Simonpeter Emokpaire APRN, PMHNP, BC / Nicole Price APRN, PMHNP, BC

to: ***release***/***receive*** the following information from my medical record to/from: _____

All APPLY UNLESS SPECIFIED

- ☐ Complete Medical record or any part thereof _____
- ☐ Medical History _____
- ☐ Psychological Report or Psychiatric Assessment _____
- ☐ Laboratory Reports _____
- ☐ Physician Orders or Progress Notes _____
- ☐ Other (please Specify _____ _____

I understand and agree that the information I am authorizing to be released may include mental health information, HIV/AIDS test results, diagnosis, treatment and related information, drug test results, and genetic testing.

I further understand that I may revoke or cancel this authorization at any time by notifying the doctor's office in writing.

To the Party receiving this information:
This information has been disclosed to you from records whose confidentiality may be protected by federal law. If so, federal regulations (42CFR part2) prohibit you from making any further disclosure of it without specific written consent of the person to whom it pertains. A general authorization for Release of Medical Information is not sufficient for this purpose. **I** release and agree to hold Barry F Gritz MD and his agents, employees and representatives harmless from all liability associated with the release of confidential patient information, I understand that Dr. Barry Gritz cannot be responsible for the use of redisclosure by a third party.

_____	_____
Patient Print Name	**Witness Print Name**
_____	_____
Signature	**Witness Signature**
_____	_____
Date and Time	**Date and Time**