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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.

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 prohibits 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