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Release of Information

Authorization to Release and/or Receive Healthcare Information

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Your name_____Birthdate_____

Recipient to release your information _____

Their address_____Phone_____Fax_____

	Billing and Scheduling		Psychiatric Assessment &Updates		Progress
	Mental Status/MSE		Crisis Intervention		Drug/Alcohol Evaluation
	Discharge Summary		Treatment Plan & Update		Medication Administration
	Diagnosis		Psychosocial Assessment & Update		Agency Documentation
	Phone Communication		Educational Testing		Background & History
	Physical Examination		Lab Results		Collaboration of Care
	Physicians Orders		Court Orders		Prescription Information
	Therapists Orders		Consultation Reports		Other:

This signed release of information (unless revoked in writing) shall terminate 90 days from the date of discharge or one year from the date of signature, whichever is the latter. By signing this release and authorization, I acknowledge that the information to be release may include material that is protected by Federal Law and may contain Personal Health Information. My signature authorizes release of all such information. I also understand that this authorization may be revoked at any time by submitting a written request and it will be honored with exception of information that has already been released. I also understand that if the person/organization authorized to receive my information is not a health plan or a health care provider, the released information may no longer be protected by Federal Privacy Regulation. A photocopy, scan or fax of this document shall have the same effect as the original copy.

By signing this document, I release above checked practitioner(s) from any liability resulting from this disclosure.

Self or Guardian X _____Date_____

Witness (if needed) X_____Date_____