Mercy Psychiatry Inc.

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8217 Mid Cities Blvd, Suite 300, North Richland Hills, TX, 76182

Tel: (817) 779 – 3716 Fax: (817) 506 – 3569

Medical Record Release Form

Patient Demographic Information:

Name: _____ DOB: _____

Address: _____

Phone: _____

Release From:

Name: _____ DOB: _____

Address: _____

Phone: _____ FAX: _____

Release To:

Name: Mercy Psychiatry

Address: 8217 Mid Cities Blvd North Richland Hills Texas, 76182

Phone: 817-779-3716 FAX: 817-506-3569

Requesting:

( ) Transfer to Care (X) All Records on File

( ) Progress Notes ( ) Collateral History

( ) Labs ( ) Other: _____

Reason or purpose for release of information are as follows:

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndromes (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

( ) **Yes**, I consent to release this information

( ) **No**, I do not consent to the release of this information

I understand that the information released is for the specific purpose stated above. Any other use of this information without written consent of the patient is prohibited. However, I understand that any disclosure of

information carries with it the potential for unauthorized re-disclosure and the information may not be protected by confidentiality rules.

Signature: _____ Date:_____