AUTHORIZATION FOR RELEASE OF CONFIDENTIAL HEALTH INFORMATION

GUIDING LIGHT PSYCHIATRY
1935 AL HWY 157, STE B
CULLMAN, AL 35058
P(256)530-4504 F(256)542-9797

Patient Name: _____
Birth Date: ____/____/____
Chart: _____

Authorization for the inspection, Use, Disclosure and Release of Confidential Health Information
This request for disclosure and release of health information is made at the request of the patient or the patient's legally authorized representative. I hereby request and authorize to release the health information of the above named patient.

Purpose of the request: ☐ Continuation of care ☐ Insurance ☐ Personal ☐ Other: _____

Protected health information requested / Authorized for release:

- ☐ History and Physical
- ☐ Office Notes
- ☐ Psychiatric Records
- ☐ Hospital Records
- ☐ Reports: Labs, Diagnostic, Pathology
- ☐ Entire Chart

For the dates of service: _____ to _____ OR ☐ ALL PAST, PRESENT OR FUTURE ENCOUNTERS

This health information may be disclosed or released from: _____
_____
_____

This health information may be disclosed or released to:

Guiding Light Psychiatry
1935 AL Hwy 157, Ste B
Cullman, Alabama 35058
Fax (256)542-9797

I understand that if my health record contains information in reference alcohol, substance use, psychiatric / mental healthcare, HIV/AIDS, intellectual disability or genetic testing, I agree to its release. Guiding Light Psychiatry is hereby released from legal responsibility or liability for the disclosure of the records to the extent and authorized herein.

I understand that this health information may no longer be protected by federal and state privacy laws once it is disclosed, and, therefore, may be subject to re-disclosure by this recipient.

By signing this form, I (the patient) understand that if the person or organization designated on this form to receive the information is not a Health Plan or Health Care Provider, some of the released information may no longer be protected by the above named confidentiality laws and regulations. I also understand that signing this Authorization is voluntary, and that I am not required to sign this Authorization in order to get treatment, payment, enrollment, or eligibility for benefits. I also understand that I may revoke this Authorization by doing so in writing at any time; except to the extent that action has been taken in reliance on the information, and that the revocation does not affect any information that was released before the revocation by sending a written notice to ATTN: Medical Records, Guiding Light Psychiatry, 1935 AL Hwy 157, Ste B, Cullman, AL 35058.

_____
Patient Name

_____
Patient Signature

_____
Date