PMR CONSULTING SOLUTIONS
Optimizing. Adapting. Overcoming.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Information

Patient Name:

Date of Birth: Gender: Male Female Other

Primary Phone: SSN #:

Street Address:

City: State: Zip Code:

I, the undersigned, hereby authorize _____

__to **release** copies of medical records to: __to **obtain** copies of medical records from:

__**verbal** relase only of medical information to:

Outpatient Service Information

Name of Business: PMR Consulting Solutions Phone Number: (717) 814-8014

Date of Service:

Purpose for Disclosure:

_____ is authorized to release the following: (Please info to be released). The medical records to be released may contain information pertaining to mental health services, drug and/or alcohol treatment.

__All of my medical-related information

__My medical information ONLY related to: _____

__My medical-related information from: _____ to _____

__Other: _____

Termination & Acknowledgement of Rights:

This authorization will terminate upon sending a written revocation to the Authorization Party, unless otherwise specified.

__ I understand that I have the right to revoke this authorization, in writing and at any time, except where uses or disclosures have already been made based upon my original permission. I might not be able to revoke this authorization if its purpose was to obtain insurance.

__ I understand that uses and disclosures already made based upon my original permission cannot be taken back.

__ I understand that it is possible that Medical Records and information used or disclosed with my permission may be re-disclosed by a recipient and no longer protected by the HIPAA Privacy Standards.

__ I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create Medical Records for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

__ I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature of Patient: _____ Date: _____

Witness: _____ Date: _____