Southwest Psychiatric Physicians

"Grow Through What You Go Through"

Authorization for the Release of Information

Patient's Name: _____ Date of Birth: _____

Reason for Releasing Information: Parent permission_____ Dates of service: _____

I, _____, hereby authorize **Southwest Psychiatric Physicians** to disclose my own identifiable health information, I understand that this is voluntary, and I may refuse to sign this authorization. I understand that if the recipient authorized to receive the information is not a health plan or health care provider the released information may no longer be protected by federal and state privacy regulations.

The health information may be sent to the following:

Name of Person _____

Address _____ City, State, and Zip code _____

Contact Person _____ Phone # _____ Fax# _____

The following information may be sent:

☐ Initial Psychiatric Evaluation

☐ Progress notes

X Verbal communication (to receive/exchange information)

X other (please specify): pick up medical records

(I understand that information relevant to HIV testing/or AIDS related diagnosis, substance abuse and treatment, mental health information, or drug test results may be contained in this information)

I understand that I may withdraw this consent only by delivering prior written notice to Southwest Psychiatric Physicians. I release Southwest Psychiatric Physicians (including all staff, officers, directors, contractors, employees, agents, and representatives) from any liability for disclosing these records because I consent to any disclosure, which is made pursuant to the terms set forth above. I understand and agree that these records may not be released if a physician chosen by Southwest Psychiatric Physicians finds this may result in harm to the physical, mental, or emotional health of the patient. I understand that Southwest Psychiatric Physicians will not condition treatment, payment, and enrollment in a health plan, or eligibility for benefits on my consent for authorization for use or disclosure.

Consent is subject to revocation at any time except to the extent that the program or person, which is to make the disclosure, has already acted in reliance on it. This authorization shall expire **1 YEAR** from the date of signature.

_____ _____

Signature of Patient Date

_____

Printed Name of Patient

Relationship to Patient Self_____

_____ _____

Signature of Witness/Title Date