Southwest Psychiatric Physicians

8535 Tom Slick Drive ♦ San Antonio, Texas 78229 ♦ (210) 582-6440 ♦ (210) 692-9021 fax

Authorization for the Release of Information

Patient's Name: _____ Date of Birth: _____

Reason for Releasing Information:_____ Dates of service: _____

I, _____, hereby authorize Southwest Psychiatric Physicians to disclose my child's or 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 Facility or Person _____

Address _____ City, State, and Zip code _____

Contact Person _____ Phone # _____ Fax# _____

The following information may be sent:

☐ Initial Psychiatric Evaluation ☐ Verbal communication

☐ Progress notes ☐ other (please specify): _____

By method of: ☐ Fax ☐ Self Pick Up ☐ Mail

(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 or Parent/Guardian Date

_____
Printed Name of Patient or Parent/Guardian

Relationship to Patient _____

_____ _____
Signature of Witness/Title Date