

## AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

### Patient Information

Name:		Date of Birth:	
Address:		Phone:	
City:	State:	Zip:	Fax:

I hereby authorize and request PsychConnect to:

- Release Information To\*:                       Obtain Information From:                       Exchange Information With:
- \*Check here if you are requesting we send electronic records. PsychConnect will only send the last year of medical records. If you would like more than that sent, please indicate dates here: \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_.
- I authorize records to be sent via facsimile.

Person/Organization:			
Address:		Phone:	
City:	State:	Zip:	Fax:

### Information to be Disclosed:

- All Mental Health Records                       All Medical Records                       Laboratory Results
- Psychiatric Evaluation                       Alcohol and Drug Evaluation / Treatment                       \_\_\_\_\_
- Counseling/Therapy Notes                       Medication History                       \_\_\_\_\_

### Purpose of Disclosure:

- Coordination of Care                       Disability Determination                       Insurance
- Psychiatric Treatment                       Confirmation of Diagnosis                       Legal
- Psychological Treatment                       Patient Request                       \_\_\_\_\_

I understand that this authorization is in effect for two years or until: \_\_\_\_\_  
unless otherwise revoked through written notice.

By signing this authorization, I acknowledge that I have read the reverse side and I release the above institution(s) and/or person(s) from legal responsibilities or liability that may arise from this act.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name of Authorized Person: \_\_\_\_\_

Signature of Authorized Person: \_\_\_\_\_ Date: \_\_\_\_\_

If signed by the person other than client, stated authority to do so below.

\_\_\_ Legal Authority    \_\_\_ Legal Guardian    \_\_\_ Parent of Minor    \_\_\_ Next of Kin    \_\_\_ Power of Attorney

**ADDITIONAL INFORMATION REGARDING DISCLOSURE OF PATIENT  
MEDICAL INFORMATION**

**PsychConnect** honors a patient's right to confidentiality of medical information as provided under federal and state law. Please read the following guidelines before signing this authorization.

**No Obligation to Sign:** You are under no obligation to sign this form, and you may refuse to do so. Except as permitted under applicable law, PsychConnect may not refuse to provide you treatment or other health care services if you refuse to sign this form. However, if you refuse to release this information by signing the form, it could result in a failure, for example, to properly coordinate your treatment with other health care providers such as your primary physician, thus making your treatment less effective. Depending on the specific situation, other potentially harmful effects could occur.

**Revocation:** you have the right to revoke this authorization, in writing, at any time before it expires. However, your written revocation will NOT affect any disclosures of your medical information that the person(s) and/or organization listed on the reverse side of this form have already made, in reliance on this authorization, before the time you revoke it. In addition, if this authorization was obtained for the purpose of insurance coverage, your revocation may not be effective in certain circumstances where the insurer is contesting a claim. Your revocation must be made in writing and submitted to your Authorized Provider.

**Re-release:** If the person(s) and/or organization authorized by this form to receive your medical information are not health care providers or other people who are subject to federal health privacy laws, the medical information they receive may lose its protection under federal health privacy laws, and those people may be permitted to re-release your medical information without your prior permission.

**Right to Inspect:** You have the right to inspect or copy the medical information whose disclosure you are authorizing, with certain exceptions provided under state and federal law. If you would like to inspect your records, contact your Authorized Provider. Inspection of your record shall be done in the presence of your Authorized Provider unless other arrangements have been agreed upon in advance.

**Signatures:** Generally, if you are 18 years of age or older, you are the only person who is permitted to sign a form to authorize the disclosure of your medical information. If you are under the age of 18, your parent or guardian must sign this form for you. There are, however, many situations in which this general rule does not apply. For more information regarding who is authorized to sign this form, contact your Authorized Providers