CEH
CENTER FOR EMOTIONAL HEALTH

Patient Information: I give permission to release the health information of:

Patient Name: _____ **DOB:** _____

Street Address: _____ **Telephone:** _____

City, State, Zip: _____ **Email address:** _____

Release Information From:

_____
(Name of appropriate facility or doctors office)

_____
(Address)

_____
(Phone number) **(Fax number)**

Release Information To:

_____
(Name of facility, doctors office, or company)

_____
(Address)

_____
(Phone number) **(Fax number)**

Please check one: ____ Communication or _____ Actual Records Released

This form is valid until: _____ (If no date inserted, it is valid 1 year from the date signed below.)

Please check all that may apply of what you want released:

☐ Office Visits/Progress Notes ☐ Clinical Comprehensive Assessment ☐ Entire patient record

☐ Laboratory Reports ☐ Medications ☐ Other: _____

Purpose of release (Please check one): ☐ Continued patient care ☐ Insurance

☐ Legal purpose ☐ Other: _____

PATIENT RIGHTS – I UNDERSTAND THAT:

I understand that I have a right to revoke this authorization at any time by notifying the Medical Record Department of the above named organization in writing. I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that I may request to inspect or obtain a copy of the information to be used or disclosed. I understand that my treatment cannot be conditioned on signing this authorization unless I am being treated so that a third party can receive my health information, such as employer for a return to work evaluation or insurance company for eligibility. If the patient is a minor, a parent or guardian must sign. I understand this permission is valid 1 year after the date of my signature unless otherwise noted.

☐ I acknowledge and hereby consent that the released information may contain alcohol, drug abuse, psychiatric, HIV results or AIDS information.

☐ I authorize the release of any records regarding drug, alcohol or mental health treatment to the person listed above.

Signature: _____ **Relationship to Patient:** _____

Print Name: _____ **Date:** _____