CENTER FOR EMOTIONAL HEALTH®

RELEASE OF INFORMATION

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:	Release Information To:
_____ (Name of appropriate facility or doctors office)	_____ (Name of facility, doctors office, or company)
_____ (Address)	_____ (Address)
_____ (Phone number) (Fax number)	_____ (Phone number) (Fax number)

Please check one: ____ Verbal Communication (phone) or

_____Written Communication (email) or

_____Actual Records Released (medical records)

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 to what you want to be 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:** _____