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Peace PSYCHIATRY

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**Patient Name:** _____ **Date of Birth:** _____

*This form when completed and signed by you, authorizes the release of protected health information from your clinical record to the person you designate.*

I authorize, _____ , MD / DO at Peace Psychiatry to… ☐ obtain ☐ release records to the following providers listed below:

1. Practice and Provider's Name _____
   Address _____ Phone _____
   City, State, Zip _____ Fax _____
   **PLEASE SEND:** _____

2. Practice and Provider's Name _____
   Address _____ Phone _____
   City, State, Zip _____ Fax _____
   **PLEASE SEND:** _____

3. Practice and Provider's Name _____
   Address _____ Phone _____
   City, State, Zip _____ Fax _____
   **PLEASE SEND:** _____

**Information allowed to be release/obtained:**

☐ Progress notes ☐ Labs/Imaging ☐ Hospitalization/Discharge Summary ☐ Referral
☐ Evaluations/Assessments ☐ Medical History ☐ Medication Report ☐ Communication
☐ Other: _____

Purpose of this Release (ex: transfer/coordination of care) _____

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by a recipient of such information and it is possible that once disclosed, the privacy of the information may no longer be protected under federal medical privacy law. I understand that this authorization gives permission to release the information above which may include drug/alcohol abuse, treatment, and psychological or psychiatric impairments, HIV/AIDS or physical conditions. A fee may be charged for copying the protected health information.

X _____ _____
Patient / Legal Guardian / Parent Signature Date Signed

*This authorization will remain in effect for two years unless you designate a different date otherwise. You may revoke this authorization at any time by giving us a written notice.*

_____ _____
Peace Psychiatry Staff Signature Date