village
FAMILY PSYCHIATRY

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RELEASE OF PATIENT INFORMATION CONSENT FORM

Patient's Name: _____ Today's Date: _____
Patient's Date of Birth: _____ Patient's MD/Therapist: _____
Patient's Social Security#: _____

NOTE: *Federal law prohibits the release of any patient's medical/psychiatric records without the prior expressed written consent of the patient and/or patient's parent/legal guardian. By endorsing the consent, you are acknowledging that you agree to waive your patient confidentiality for the release of pertinent information about your case and that you understand that such information may only be released to persons and for purposes specified here.*

I hereby authorize that the following information from my medical records may be released:

_____ Admission/Discharge Assessments _____ Medical/Lab Reports

_____ Physician/Therapist Progress Notes _____ Correspondences/Letters

_____ Psychological Evaluation _____ Verbal Communication with:_____

_____ Education Evals./School Reports/IEP's

_____ Other (please be specific): _____

_____

I further hereby authorize that such information from my medical records containing personal healthcare information may be disclosed to ____ and/or received from ___ (check one or both) the following person(s) or organizations.

Name of person(s) or Organization: _____

Address: _____ Telephone #: _____
_____ Fax #: _____

Reason/Purpose for Release of Information: _____

_____

This authorization will expire in 6 months or before that time if specifically rescinded in writing.

Patient's Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Witness' Signature: _____ Date: _____

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