Authorization to Release Health Information

Client Name: _____ Date of Birth: _____

I HEARBY AUTHORIZE **Foundation Psychiatry, P.C.** to release the following medical and clinical information:

- Medical, psychiatric, psychological and therapy evaluations and progress notes
- Laboratory Results
- Verbal/Written Communications
- Two Way Conversations
- Treatment Plans
- Exclude the following information: _____

For the purpose of: __ comprehensive case planning/continuity of care

__ other (specify) _____

with the following:

Name: _____ Phone/Fax: _____

Other: _____ Phone/Fax: _____

Other: _____ Phone/Fax: _____

The above-mentioned Protected Health Information may be subject to re-disclosure by the party receiving the information and may no longer be protected by the privacy rules. I understand that this authorization to exchange information becomes effective when I sign this release and that I may revoke this authorization at anytime by written notice to Foundation Psychiatry, P.C. However, such a revocation shall not affect any disclosures already made in reliance on your prior authorization. My refusal to sign this form will not affect my ability to receive care at Foundation Psychiatry, P.C. This authorization expires in 12 months and any further disclosure after that time will require signing a new form.

Client Signature: _____ Date:_____

Signature of Parent/Legal Guardian if applicable:

Signature:_____ Date:_____

Witnessed: _____ Date: _____