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PSYCHIATRIC CONSULTANTS AND THERAPISTS, SC

AUTHORIZATION FOR RELEASE/REQUEST OF INFORMATION/RECORDS

I, _____ **Date of Birth:** _____
First and Last Name *mm/dd/yyyy*

hereby give my permission to **Psychiatric Consultants & Therapists, SC**, to release or request from a third-party information contained in my medical record. I understand that my medical record may contain information concerning my psychiatric, psychological, drug or alcohol abuse, sexual abuse treatment, HIV/Acquired Immune Deficiency Syndrome (AIDS) and/or related conditions, and that under law these records are classified as privileged and confidential and cannot be released to me or those designated by me or my legal guardian without an expressed and informed consent. In addition, I understand that those records will not be released to entities other than those designated by myself or my personal representative or otherwise provided in federal law.

This information will be released/requested upon request to the following parties:

Name (First and Last): _____

Company/Clinic Name (if applicable): _____

Street Address: _____

Phone Number: _____

Fax: _____

Reason for request/release of confidential medical records:

☐ **Provider's Request** ☐ **Coordination of Care** ☐ **Legal Investigation** ☐ **Leaves of Absence**

☐ **Patient's Request** ☐ **Accomodations** ☐ **Transfer of Care** ☐ **Other**

If other, please specify _____

Dates of Service to be released/requested: _____

The type of information to be disclosed/requested is as follows:

To Be Released * *from* ***PCT***

- ☐ Treatment Plans
- ☐ Progress Notes
- ☐ Health/Medical Records (if applicable)
- ☐ Letter(s) of Progress
- ☐ Initial Evaluation/Assessment
- ☐ Verbal Communication
- ☐ Other (Specify):_____

To Be Requested * *from third parties*

- ☐ Treatment Plans
- ☐ Progress Notes
- ☐ Health/Medical/Academic Records
- ☐ Psychological/Psychiatric Evaluations
- ☐ Court Documents
- ☐ Verbal Communication
- ☐ Other (Specify): _____

** In the case of notes documenting or analyzing the contents of conversation during a private counseling session ("process notes"), such records may be protected from disclosure under the HIPAA Privacy Rule).*

____(initial) I understand that I have the right to withdraw my authorization at any time except to the extent that action has already been taken pursuant to the authorization. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to **Psychiatric Consultants & Therapists SC**

____(initial) I understand that authorizing the disclosure of this health information is voluntary, I can refuse to sign, and Psychiatric Consultants & Therapists, SC will not base my treatment on whether I provide authorization for the requested use or disclosure. I understand that I may inspect or copy the information to be disclosed, as provided in CFR164.524 (with reasonable charge). Also provided in CFR164.524 there are exceptions for PCT to release information.

____(initial) I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of the information and is no longer protected by federal confidentiality laws or Psychiatric Consultants & Consultants, SC will not be held liable for information disclosed to another party per the client's request.

____(initial) I understand that **Psychiatric Consultants & Therapists, SC** will release only the minimum amount of information necessary to fulfill a request.

This authorization shall expire one year from the date signed below. This agreement is subject to revocation in writing at any time.

Client/Guardian Signature_____

Today's Date_____
mm/dd/yyyy