Total Mental Wellness Release of Information

Authorization and Consent to Release Medical Information

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Date: _____

Patient's Name: _____ Date of Birth: _____

I authorize the above mentioned provider(s), whose office is located at the address listed above to disclose and/or obtain information from the following physician, psychiatrist, hospital and other treatment provider or organization, relative, friend, or any other person I choose to name below: (Please see the front desk for additional pages if needed)

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

By signing below I acknowledge that the following information may be released, discussed, or disclosed. If you agree to the release, please check the option you agree to.

_____ Complete Medical/Psychiatric Record

_____ Diagnosis and Medication Records

_____ Substance Abuse Information (including assessment and treatment records)

_____ Treatment Plan

_____ For Incoming or Outgoing Referrals

_____ Results of Labs/Tests: _____

_____ Correspondence Regarding: _____

_____ Other: _____

I am signing as a patient, guardian and/or responsible party. I further understand the records released may contain references to family and me. I further waive and release the above named parties from any liability resulting from the release of the above information. I also understand that my records are protected under federal regulations governing Confidentiality of Protected Health Information (PHI) under HIPAA. I also understand that I may revoke this authorization and must do so in writing and present this written revocation to the office of Total Mental Wellness. Unless otherwise revoked, this consent expires in 12 months from this date.

Signature: _____ Date: _____