Psychiatric Medicine Center, LLC
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AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Complete this form to give permission for medical information to be sent or requested

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____/_____/_____

I hereby authorize Psychiatric Medicine Center, LLC to:

- ☐ REQUEST records FROM the person/office listed below
- ☐ SEND records TO the person/office listed below

Name of Provider/Office: _____

Address: _____

Phone: _____ Fax: _____

INFORMATION YOU AUTHORIZE OUR OFFICE TO SHARE/RECEIVE:

- ☐ Entire Medical Record (Including all Psychiatric/Psychological/Substance Use)
- ☐ Progress/Office Notes
- ☐ Medication List
- ☐ Substance Use Disorder Information
- ☐ Other: _____

This authorization expires 12 months after the date I signed, unless I write a different expiration date below:
Date: _____

By signing this form, I understand that my authorization is voluntary and may be revoked in writing at any time, except for the information already released. I understand that information shared may no longer be protected by HIPAA and may be redisclosed.

_____ _____
Patient Name Patient or Legal Guardian Signature

_____
Date