Integrative Psychological Medicine
Authorization for Disclosure of Health Information

I hereby authorize _____ (Name of Facility or Provider)

Phone #: _____ Fax #: _____ to release my Mental Health information from their records.

Patient Name: _____ D.O.B.: ____/____/_____ SS#: XXX-XX-_ _ _ _

Patient Street Address:

_____

City: _____State: _____ Zip Code: _____

Date(s) of Treatment Requested:

_____

Information to be disclosed (check all applicable items to be released):

□ Progress Notes □ Treatment Plans □ ER
□ Medication Records □ Therapy Notes □
□ HIV testing □ History and Physical □
□ Nurse's Notes □ Other _____ Lab ___
□ Hospitalization Discharge Summary

Purpose or Need for The Disclosure Is:

____Continued Medical Care ____ Insurance _____Legal _____ Patient's Own Use

Other (Specify) _____

The Information May Be Disclosed To:

Recipient's Name: _____ (Name of Facility)

Street Address:

_____

City: _____State: _____Zip Code: _____

Phone #: _____Fax #:

_____

I understand that my refusal to sign this form will not adversely affect my ability to receive mental health services but may cause a delay of care. However, information will not be released to the above-indicated recipient without my signature.
I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse,
mental health, genetic information, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AIDS related
complex (ARC) and/or human immunodeficiency virus (HIV).
I acknowledge that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no
longer protected by Federal Law.
I understand that I have the right to revoke this authorization, in writing, at any time. I understand that actions
taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

This authorization expires on: _____ (Date) or upon the following event:

_____

(If no date or event is specified, this authorization will expire one (1) year from the date of signature).

Fees: I understand and agree that there may be costs associated with this request in compliance with State copying laws.

_____ _____

(Signature of Patient or Personal Representative) (Date of Signature)