



Southern Psychiatry

CONSENT FOR RELEASE OF MEDICAL INFORMATION

Patient's Name: _____

Social Security #: _____ Date of Birth: _____

I hereby authorize release of medical records as specified below.

Release from: _____ Release to: _____

Address: _____ Address: _____

Phone: _____ Phone: _____

Fax: _____ Fax: _____

Type of Information to be released from medical record:

Intake Note Other: _____

Progress Notes _____

Discharge Summary _____

Medication List _____

Labs/Test Results _____

The consent is given freely and voluntarily. Any information obtained shall not be released by the above-named person or organization to any other persons or organizations unless I so authorize, except as mandated by state and federal law. In the event that information is related by a third party to unauthorized persons, the undersigned hereby releases Southern Psychiatry and its providers from any and all liability for such unauthorized review of information. This consent is subject to revocation at any time except to the extent that action has been taken in reliance thereon. I further understand that my records may contain information regarding psychiatric treatment and alcohol & drug treatment.

Patient's signature Date

Signature of Legal Guardian (if necessary) Date

Signature of Witness Date

This release expires one year from date of signature unless specified here: _____

*Consent is invalid if signature is not witnessed and dated.

Office use only: Copies of _____ were sent to _____
on _____ by _____.