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**
__ **Progress Notes**
__ **Discharge Summary**
__ **Medication List**
__ **Labs/Test Results**

Other: _____
_____
_____
_____
_____

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 to 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 _____.

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