MILLENIA

PSYCHIATRY & RESEARCH

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Authorization for Release of Confidential Information

Patient:	DOB:

I HEREBY AUTHORIZE: MILLENIA PSYCHIATRY & RESEARCH

☐ TO OBTAIN MY INFORMATION FROM:
☐ TO PROVIDE MY INFORMATION TO:
☐ TO EXCHANGE INFORMATION WITH:

DOCTOR/PRACTICE/INDIVIDUAL(S)
ADDRESS/CITY/ST/ZIP
PHONE
FAX

THE FOLLOWING INFORMATION IS TO BE RELEASED FOR THE PURPOSE OF _____

☐ HISTORY AND PHYSICAL EXAM
☐ PSYCHIATRIC EVALUATION
☐ PSYCHOLOGICAL TESTING
☐ PLEASE NOTE:
☐ PROGRESS NOTES
☐ PROFESSIONAL CONSULT
☐ OTHER:_____

I HEREBY CONSENT TO THE RELEASE OF THE ABOVE INFORMATION REGARDING MY TREATMENT, AND/OR OUTPATIENT CARE FOR MY IMPAIRMENTS, INCLUDING PSYCHOLOGICAL OR PSYCHIATRIC IMPAIRMENT(S), DRUG AND ALCOHOL ABUSE, OR HIV/TRANSMITTED DISEASE. I UNDERSTAND THAT ONCE MY INFORMATION HAS BEEN RELEASED, THE RECIPIENT MIGHT RE-DISCLOSE IT, MY DOCTOR HAS NO CONTROL OVER IT AND PRIVACY LAWS MAY NO LONGER PROTECT IT. I HAVE BEEN INFORMED OF THE SPECIFIC TYPE OF INFORMATION REQUESTED AND IF KNOWN, THE BENEFITS AND DISADVANTAGES OF RELEASING THE INFORMATION. ALSO, I HAVE BEEN INFORMED THAT TREATMENT SERVICES ARE NOT CONTINGENT ON MY DECISION CONCERNING THIS RELEASE. THIS AUTHORIZATION IS VALID FOR THREE MONTHS (90 DAYS) UNLESS OTHERWISE REVOKED. I GIVE THIS CONSENT VOLUNTARILY.

SIGNATURE OF PATIENT: (Parent/Guardian if under 18)	DATE: / /

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