



PsychHealth, Ltd.

Authorization to Exchange Patient Records or Information

Patient Full Name: _____ Member ID# _____

Patient Address: _____

I hereby authorize the following organizations and/or practitioners to release, obtain and exchange information:

- PsychHealth, Ltd
- Treating Behavioral Health Practitioners
- Primary Care Physician
- Other Treating Medical Specialists

PCP Information

PCP Name: _____	Address: _____
Telephone #: _____	_____
Fax #: _____	_____

Specific Authorization is required for Release of Information for Mental Health/ Substance Abuse / HIV as mandated by State and Federal law.

In order for the specific information to be released the patient must initial by each applicable category.

Mental Health Evaluation & Treatment Substance Abuse Evaluation & Treatment
 HIV Records

For the purposes of: Coordination of Care

Clinical Information:

Diagnostic Impression: _____ _____ _____
Medications: _____ _____
Recommendations/Suggested Treatment Plan: _____ _____ _____
Coordination of Care Issues: _____ _____ _____

This authorization is valid for one (1) year from the date signed, or expires on the following date:

_____ Date

I understand I have the right to inspect and copy any written information to be disclosed. I understand I have the right to revoke this authorization at any time, in writing, however written notice shall have no effect on information previously released in good faith. I understand that failure to sign this authorization may hinder the above indicated purpose being achieved.

Date of Authorization: _____

Signature of Patient

Witness

Signature of Parent/Legal Guardian

Relationship to Patient