MERIDIAN
PSYCHIATRIC PARTNERS

RELEASE OF INFORMATION

AUTHORIZATION FOR RELEASE OF INFORMATION

PATIENT INFORMATION:

PATIENT'S NAME _______________ BIRTHDATE _______________

ADDRESS _______________ PHONE NUMBER _______________

CITY _______________ STATE _______________ ZIP _______________

MAIDEN/OTHER NAMES _______________

I authorize the use/disclosure of my mental health records and/or information to:

NAME _______________ PHONE NUMBER _______________

ADDRESS _______________ FAX NUMBER _______________

CITY _______________ STATE _______________ ZIP _______________

This authorization is limited to the following specific types of information:

☐ Date(s) of Treatment From: _______________ to _______________ or a specific date: _______________

DESCRIPTION OF MY MENTAL HEALTH RECORDS AND/OR INFORMATION TO BE DISCLOSED:

☐ Hospital Consult –Psychology/Psychiatry/Neuropsychology

☐ Office Visit –Psychology/Psychiatry/Neuropsychology

☐ Hospital Progress Notes –Psychology/Psychiatry/Neuropsychology

☐ Neuropsychological Evaluation and Testing Data/Results

☐ Testing Data – Psychology/Psychiatry

☐ Labs

☐ X-Ray

☐ Billing Records

☐ Other: _______________

SPECIALLY PROTECTED RECORDS:
(Check and Initial the following)

☐ Alcohol/Drug Abuse _______________

☐ Genetics _______________

☐ HIV/AIDs _______________

If you are authorizing the disclosure of psychological tests, such tests may only be disclosed to a psychologist that you have designated.

(CONTINUED)

625 North Michigan Avenue, Suite 2550, Chicago, IL, 60611 Phone: 312-640-7740 Fax: 312-640-7736 www.meridianpsychiatricpartners.com

AUTHORIZATION FOR RELEASE OF INFORMATION (CONTINUED)

Information is being released for the purpose of:

☐ Treatment coordination/planning

☐ Other: ____________________

I understand that:

☐ This consent will automatically expire one year from signing unless a different date of expiration is specified here:

____
DATE

☐ I have the right to copy and inspect the information being disclosed.

☐ This information may be transmitted via written word, facsimile, or over the phone.

Restrictions if any: ____________________

☐ Authorization for this release of information can be revoked at any time. To revoke this authorization, I understand that I must provide a statement in writing with my request. Revocation will not apply to information that has already been released.

☐ I understand that the person or agency who receives my mental health information, genetic testing, alcohol and drug abuse records or HIV/AIDs records may NOT disclose it to someone else without my specific permission, unless permitted by law.

☐ If I refuse to consent to the release of information specified above, information will not be disclosed/obtained.

☐ I may be charged a copying fee to complete this request.

SIGNATURE

PATIENT SIGNATURE (AGE 12 OR OLDER)	DATE
PARENT/GUARDIAN OR OTHER AUTHORIZED AGENT SIGNATURE (IF APPLICABLE)	DATE
PRINTED NAME OF PARENT/GUARDIAN OR OTHER AUTHORIZED AGENT (IF APPLICABLE)	RELATIONSHIP TO PATIENT

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