Authorization for Release of Information

Name: _____ Date of Birth: _____

Address: _____ City, State, Zip: _____

☐ **I authorize Tranquility Psychiatry and Counseling Services to exchange information with:**

Name: _____

Address: _____

Phone: _____ Fax: _____

Email: _____

PURPOSE OF THIS REQUEST: ☐ Healthcare ☐ Insurance Coverage ☐ Personal ☐ Other

TYPE OF RECORDS AUTHORIZED: ☐ Psychiatric/Psychological Evaluation and/or Treatment

SPECIFIC INFORMATION AUTHORIZED: (select one or more as appropriate)

☐ **ALL INFORMATION CAN/SHOULD BE EXCHANGED AS NECESSARY**

☐ Assessments ☐ Progress Notes ☐ Laboratory Test Results

☐ Diagnostic Impression ☐ Discharge Summary ☐ Treatment Plans

☐ Treatment Summary ☐ Other: (please describe)_____

Periodic Use/Disclosure: I authorize the periodic use/disclosure of the information described above to the person/provider/organization/facility/program(s) identified as often as necessary to fulfill the purpose identified in this document. My authorization will expire when I am no longer receiving services from Tranquility Psychiatry and Counseling Services.

I understand that:

- I do not have to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment.
- I may cancel this authorization at any time by submitting a written request to Tranquility Psychiatry and Counseling Services.
- If the person or facility receiving this information is not a healthcare or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- If the authorized information is protected by Federal Confidentiality Rules 42CFR, Part 2, it may not be disclosed without my written consent unless otherwise provided for in the regulations.
- Release of HIV related information requires additional information.

Signature of Patient or Representative: _____

Printed Name of Person Signing Form: _____

Relationship to Patient (*if requester is not the patient)*: ☐ Parent ☐ Legal Guardian ☐ Other: _____

Date :_____ Signature of Patient (required if age 13 or older): _____