AUTHORIZATION FOR
Comprehensive MedPsych Systems, Inc.
TO RELEASE/OBTAIN PATIENT INFORMATION

Patient Name: ____ DOB: ________________________

Address: ______________________________ City: _______________________ State: ____ Zip: ________

Home Phone: ____________________ Cell Phone: ____________________ Work Phone: __________________

☐ I hereby give my provider(s): Name: ______________________

Comprehensive MedPsych Systems, Inc.
Headquarters: 1090 South Tamiami Trail
Sarasota, Florida 34236
Ph: (941) 363-0878 Fax: 716-242-3360

Permission to release information to the following:

Name: ____

Address: ____

____

Phone: ____________________ Fax: __________________

☐ I hereby give:
Name: ____

Address: ____

____

Phone: _________________________ Fax: ____________________

Permission to release information to my provider(s):
Name: ____
Comprehensive MedPsych Systems, Inc.
Headquarters: 1090 South Tamiami Trail
Sarasota, Florida 34236
Ph: (941) 363-0878 Fax: 716-242-3360

I hereby give permission to release or have the following documents given to the above named person:

____ **All Mental Health Notes / Information**
____ Initial Intake – History and Physical
____ Psychiatry Notes
____ Psychotherapy Notes
____ Neuropsychological/Psychological Testing Report
____ Medical Records
____ Treatment Summary
____ Lab Work
____ Other ______________________
____ Testing Raw Data *(release only to a psychologist)*

For the purpose of:

____

____

Please initial: _____ I acknowledge, and hereby consent to such, that the protected health information (PHI) released may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. I also acknowledge that I have read the above and authorize the disclosure of the protected health information (PHI) as stated.

I understand that:
1. I may refuse to sign this authorization and that it is strictly voluntary
2. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization
3. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
4. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
5. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. However, we may refuse to provide you access to certain notes, reports, testing raw data, or information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative legal/forensic proceedings or for other reasons in accordance with state, federal, workers compensation and/or HIPAA law.
6. I may receive a copy of this form after I sign it.

Signature of Patient / Patient's Representative: ____ Date: ____________

Print Name of Patient / Patient's Representative: ____

If Patient's Representative, what is the relationship: ____

ID Verified by: _________ (CMPS staff initials)

Note: This authorization will expire one year from the date signed.