AUTHORIZATION FOR
Comprehensive MedPsych Systems
TO RELEASE/OBTAIN PATIENT INFORMATION

Patient Name: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____ Phone: ____/_____

☐ hereby give my provider(s) _____ at CMPS permission to ***RELEASE*** the information noted below:

TO :

Name: _____

Address:_____

_____

Phone: _____ Fax: _____

☐ hereby give my provider(s) _____ at CMPS permission to ***REQUEST*** the information noted below:

FROM :

Name: _____

Address:_____

_____

Phone:_____ Fax: _____

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 (or summary)
____ NP/Psychological Testing Report
____ Treatment Summary Only
____ Lab Work
____ Billing Statement
____ Dates of Service Only
____ Verbal Communication Only
____ Other _____

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 information below 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.

Please return this form to the Medical Records Department at CMPS with a copy of your photo ID:

Mail:
1090 S. Tamiami Trail
Sarasota, FL 34236

Fax:
716-242-3360

Email:
lisagolden@medpsych.net