

**AUTHORIZATION FOR RELEASE
OF PSYCHIATRIC RECORDS
(Please Print)**

Sheehan Counseling Center P.A.

Patient Name _____ Date of Birth _____

Address _____

Daytime Phone Number _____

I hereby authorize my physician(s) and/or administrative and clinical staff at

to disclose the protected health information described below to:

Name _____ Mail _____

Address _____ Pick Up _____

Information _____ All Psychiatric Records
To be released _____ ONLY the information described as Follows _____

(**NOTE: A fee
may be charged for
providing your records.**)

This protected health information is to be disclosed for the following purpose: _____

I understand that my physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits on whether I provide authorization for a requested disclosure except if health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Privacy Contact of the practice I authorized above to disclose the specified protected health information. I understand that a revocation is not effective to the extent that action has already been taken in reliance on the authorization or during an insurance claim contestability period if my authorization was obtained as a condition of obtaining insurance coverage.

I understand that a photocopy of this authorization shall have the same force and effect as the original authorization.

I understand that information disclosed pursuant to this authorization may be re-disclosed by the recipient and may no longer be protected by federal or state law.

EXPIRATION DATE: This authorization is valid until _____, at which time this authorization to disclose this protected health information will expire. If no expiration date is indicated above, I understand that this authorization will be valid for ninety (90) days from the date signed.

Signature of Patient/Legal Representative

Date

Relationship to Patient

Witness

Date