Link Psychiatry

RELEASE OF HEALTH INFORMATION AUTHORIZATION FORM

I authorize Link Psychiatry to release my mental health records (excluding psychotherapy notes) and other health and health care information to:

Name _____
LAST FIRST MIDDLE

Address _____
STREET CITY STATE ZIP

Phone _____ Fax _____

I allow the following information to be released:

- ☐ History & Evaluation
- ☐ Progress Notes
- ☐ Discharge Summary
- ☐ Diagnostic and laboratory test results
- ☐ Billing Statements
- ☐ Drug and Alcohol Abuse Information
- ☐ Psychological Test Results

The purpose of this release is:

- ☐ At my request;
- ☐ To assist in my care, including the following: to increase my doctor's knowledge about my needs, current care, and prior care; to coordinate care with other providers; to coordinate payment for services; and for my doctor to discuss my health with my friends, family, and important social contacts.

I understand that if I grant permission to Link Psychiatry to release my private information to persons or entities that are not legally bound to maintain my privacy, that my privacy may no longer be legally protected. I understand that this authorization is voluntary and that I may refuse to sign it without jeopardizing my care with Link Psychiatry, except in cases where my doctor must communicate with an outside entity to ensure that the terms and conditions of services provided by Link Psychiatry are met. I understand that I have the right to revoke this permission at any time, but that Link Psychiatry is unable to retract any information that has already been released. If I choose to revoke this permission, I will do so in writing. This authorization is effective immediately and remains in effect for one year from the date it is signed, unless it is explicitly revoked in writing.

Name _____ Date of Birth _____

Signature _____ Date _____