Consent for Authorization or Release of Information and/or Medical Records

Pursuant to Federal Guidelines concerning my right to confidentiality, I ____________________

Date of Birth___________________Social Security Number______________________________

Authorize and request Women's and Children's Center for Mental Wellness:

Communication with:	Release to and/or Obtain information from:
1. ____________________________	1. _______________________________
2. ____________________________	2. _______________________________
3. ____________________________	3. _______________________________
4. ____________________________	4. _______________________________
5. ____________________________	5. _______________________________

Specific items to be released and/or obtained to include information pertaining to:

☐ Diagnosis ☐Progress ☐Admit Note ☐Medical status/diagnosis ☐Prognosis

☐Psychiatric Evaluation ☐ Medications and Treatments ☐Discharge Summary

☐Physicians Orders ☐Psychosocial History ☐Psychological Testing ☐Progress Notes

☐Laboratory Reports (Including HIV Status, STD if applicable)

☐Need for Emergency Care or Intervention ☐Substance Abuse History

☐Other (specific) ____

Reason for Release: ☐Facilitate ongoing care ☐Continuity of Care ☐Other:________________

Revocation of Consent: I understand that I may revoke this consent to release information at any time. I also understand that any release of information prior to my revocation shall not constitute a breech of my right to confidentiality. Unless I revoke this authorization prior to such time, this authorization shall expire six months after discharge from the clinic.

DISCLOSURES REQUIRING SPECIAL CONSENT: My signature below authorizes the release of healthcare information relating to the testing, diagnosis, or treatment for:

☐HIV/AIDS ☐STD ☐Mental Health/psychiatric Disorders ☐Substance Abuse/treatment

Signature of Patient__________________________________Date_____________________

Signature of Legal Guardian__________________________________ Date______________

Witness____ Date______________

Women's and Children's Center for Mental Wellness

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