

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 breach 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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