## 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_____


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