

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION
MENTAL HEALTH AND/OR SUBSTANCE ABUSE

Patient Information

Entity Information

Name: _____

Name or Title of Person or Organization

Date of Birth: _____

RELEASING information

Last 4 of Social: _____

Name or Title of Person or Organization -
RECEIVING information

Initial the items you would like to be released:

_____ Psychiatric Evaluation _____ All Records

Dates of Service to be Released: _____

_____ Progress Notes _____ Other

_____ Lab Reports _____

I understand that my records are protected under the Federal and State Confidentiality regulations and cannot be released without my written consent unless otherwise provided for in regulations. Federal regulations prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. I also understand that I may revoke this consent (in writing) at any time unless action has already been taken based upon it.

This information authorized for release may include records which may indicate the presence of a communicable or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS), as well as any drug / alcohol related data. I understand that this consent is valid for (1) year from the date signed and that I can revoke it at any time. I further acknowledge that the information to be released was fully explained to me and this consent is given of my own

Signature of Client or

Authorized Representative: _____

Date: _____

Signature of Witness: _____

I understand that I may cancel this authorization at any time by signing this notice below. However, if I cancel this authorization, I also understand that the cancellation will not affect any action Kaur Psychiatric Associates, PA took in reliance on this authorization before receipt of this cancellation.

Signature Authorizing Cancellation: _____

Date Authorization Cancelled: _____

***If records are greater than 25 pages, please MAIL, do not fax - Thank you!**