My Psychiatric Partner, LLC

AUTHORIZATION TO RELEASE HEALTH INFORMATION

1. Patient information:

First name __________________ MI____ Last name ________________________

Date of Birth ____________________

Previous name(s) ____

Address ____

City __________________________ State _________ Zip code ________________

Phone ___________________ E-Mail (optional) ____________________________

2. Person, organization, or facility to whom I authorize sending the information:

Organization(s) and/or person name _____________________________________

Relationship to patient ____

Address ____

City __________________________ State__________ Zip code________________

Phone (Optional) ___________________ Fax (Optional) ____________________

Information needed By date ____

3. Information to be Released

I understand that MPP will release all written information that it has retained about my care, for all dates of service. This release includes information about clinical history, family history, behavioral history, clinical results, diagnoses, treatment modalities, medications, treatment plans, symptoms, prognosis, progress notes, alcohol and drug use, billing records and other information.

In addition to giving permission for written information to be released, I also permit MPP and the third party named in Section 2 to communicate verbally about my health information.

If you do not want to give your permission for MPP and the third party named in Section 2 to communicate verbally about your health information, or you would like to restrict what written information is released, please specify below:

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4. Patient Understanding

I understand that by signing this form, I am authorizing MPP to release my personal health information to the person, organization or facility named in Section 2.

I may stop this authorization at any time by writing to MPP and to the person, organization or facility named. If MPP or the person, organization or facility named has already released health information based on my authorization, my request to stop will not apply to that health information already released.

I understand that once the health information specified in Section 3 is sent to the third party named in Section 2 above, that information is no longer under the control of MPP and could be re-disclosed without permission from MPP by the third party that receives it.

I understand that if the organization named in section 2 is a health care provider, they are not to condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization form. Likewise, MPP will not condition treatment or payment on whether I sign this form.

This authorization will end one year from the date this form is signed, unless a different date or specific event is indicated below:

End Date _________________ Or Specific Event ___________________________

Patient Name ____

Signature ____________________________________ Date ___________________

OR

Legally Authorized Representative

Name ____

Relationship to Patient ____

Signature ___________________________________ Date ___________________

5. Submission Instructions

1. Complete all sections of this form.

2. Mail the form to:

   My Psychiatric Partner, LLC
   6221 Riverside Drive, Suite One North
   Dublin, Ohio 43017

   Or, you may fax the form to:
   1-855-677-1677

For MPP Use:

Sender Contact Information

Name ___________________________________Title _______________________

Phone ____________________________ Fax _________________________

Email Address ____