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:

_____
_____
_____
_____
_____
_____

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 on whether I sign this authorization form. Likewise, MPP will not condition treatment 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
   8483 Torwoodlee Court
   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 _____