Form 3 Release of Information

Records Release of Authorization
For the release of Protected Mental Health Information

By signing this form, confidential psychological and psychiatric information can be released to and/or discussed with the people or agencies listed below unless noted by exclusions or limitations. This form is signed voluntarily and may be revoked at any time. All disclosures made pursuant to this form are valid as long as they were made before the date of revocation.

A Child and Family Psychiatry LLC

750 Cross Pointe Rd Suite D

Gahanna, OH 43230

Phone 614.768.2700 Fax 937.998.1118

Patient Name

Patient DOB

I authorize my provider to psychological/ psychiatric mental health information to/from the second party as directed below

- ◯ Release and Receive
- ◯ Release Only
- ◯ Receive Only

Second Party Name

Address

Fax Number

Phone Number

Type of Information to be disclosed

- ◯ I authorize disclosure of all health information including information relating to medical, pharmacy, mental health, substance abuse, and psychotherapy.
- ◯ I authorize only the disclosure of the following information(complete next field)

Information to be disclosed:

Purpose of records to be released/ received outside the continuity of care

Legal Guardian/ Personal Representative name if not being signed by the client

FORM IS NOT VALID WITHOUT Today's Date

I understand that treatment, payment, enrollment in a health plan, or eligibility for benefits is not dependent on my signing this authorization. By signing below, I acknowledge that I have read and understand this document and that I have voluntarily given my provider authorization to disclose my records. I understand that I may revoke this authorization at any time by providing a written notice to my provider however the revocation will not have an effect on any actions taken prior to the date my revocation was received. I understand that my information may be redisclosed by the authorized person/ organization receiving the information, and at that point, the information may no longer be protected under the terms of this agreement. This authorization will expire 1 year following the date signed unless revoked in writing.
Signature of the patient/legal guardian