*V*ALLEY *P*SYCHIATRIC *A*SSOCIATES, *P.C.*

*C*HILD, *A*DOLESCENT, AND *F*AMILY *P*SYCHIATRY
*F*ORENSIC *M*ENTAL *H*EALTH *S*ERVICES

190 Lime Quarry Rd, Suite 115, Madison, AL 35758, **Phone:** 256-270-9483, **FAX:** 256-325-0340

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient name	Date of Birth	Sex	Social Security No.
Address	City	State	Zip

I hereby authorize ***V*ALLEY *P*SYCHIATRIC *A*SSOCIATES, P.C.**
TO…

☐ RELEASE TO: (and/or) ☐ OBTAIN FROM:

Name	Phone		Fax
Address	City	State	Zip

The following information pertaining to treatment:

TREATMENT FROM________________________ TO ______________________________________

- ☐ Acknowledgement of Admission & Discharge
- ☐ Discharge Planning
- ☐ History & Physical
- ☐ OTHER (Specify)____
- ☐ Educational Testing
- ☐ Discharge Summary
- ☐ Psychological Testing

PURPOSE FOR DISCLOSURE____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

I UNDERSTAND THAT THIS AUTHORIZATION WILL AUTOMATICALLY EXPIRE NINETY (90) DAYS FROM DATE SIGNED (_____/______/______)

I authorize the use or disclosure of my protected health information (PHI) as described. I understand that the information I authorize a person or entity to receive may be **re-disclosed** and is no longer protected by federal privacy regulations.

It is often necessary to release your health information via facsimile when it is needed for continuing care. We confirm receipt of information when it is FAXED. I authorize transmission of my health records in situations where this information is needed for continuing care.

REVOCATION: This authorization to release confidential information may be revoked by me, in writing, at any time, except to the extent that action has already been taken.

I understand that authorizing the disclosure is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. If I have questions about disclosure of my health records, I may contact the Health Information Director at 256-306-4128.

____ ____________ __________________________

Signature of Patient/Representative | Date | Relationship to Patient

____ ____________

Witness | Date