PSYCHIATRIC MEDICAL SERVICES
AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION

Please complete this form to allow Adapt Psychiatric Medical Services to request records from your previous providers. Completion of this form is optional and not required to establish care at Adapt Psychiatric Medical Services but will help us provide continued care for the patient.

I authorize:

(Physician Name) (Address and/or Phone/Fax)

to use and disclose specific health information regarding:

(Patient Name) (Date of Birth)

to Adapt Integrated Health Care: **Psychiatric Medical Services**
621 W Madrone St., Roseburg, OR 97470
Fax: 541-440-3554

for the purpose of (check all that apply):

☐ Continuity of Care ☐ Phone Conferencing ☐ Other (specify):

Please include (check all that apply): ☐ Chart Notes ☐ Lab/Path Reports ☐ Radiology Reports ☐ EKG Reports ☐ Diagnostic Testing ☐ Immunization Records ☐ Other, please specify timeframe, diagnosis, or specific reports from date patient was last seen:

If we are requesting this authorization from you for our own use and disclosure or to allow another health care provider or health plan to disclose information to us:

- We cannot condition our provision of services or treatment to you on the receipt of this signed authorization;
- You may inspect a copy of the protected health information to be used or disclosed;
- You may refuse to sign this authorization; and
- We must provide you with a copy of the signed authorization.

You have the right to revoke this authorization at any time, provided that you do so in writing, and except to the extent that we have already used or disclosed the information in reliance on this authorization or to the extent you signed this authorization as a condition to insurance coverage. To revoke this authorization, please contact our office. Unless revoked earlier or otherwise indicated, this authorization will expire **180 days** from the date of signing.

Please initial each statement of consent.

_____ I consent to the disclosure of my HIV/AIDS information.

_____ I consent to the disclosure of my mental health information.

_____ I consent to the disclosure of my genetic testing information.

_____ I consent to the disclosure of my drug/alcohol diagnosis, treatment, or referral information, which requires under federal law a description above of how much and what kind of information is to be disclosed.

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

_____ _____

Patient or Guardian / Personal Representative signature (circle one) **Date**

_____ _____

Printed name of Patient **Printed name of Signatory and relationship, if not Patient**