Partners for Behavioral Health and Wellness
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REQUEST AND AUTHORIZATION TO RELEASE RECORDS AND INFORMATION

I, ________________________, born on _____________, authorize ________________________
Patient Name (print)   Clinician Name

_____**To Release Records To:**
_____**To Obtain Records From:**
_____**To Communicate/Speak With:**

Name ____

Address ____

Phone:_____________________________   Fax: ____

This information is for treatment planning and ongoing care.
If for other reasons, please describe:
____

This authorization and request to release or obtain information from my records is fully understood as to the nature of the records and information and the implications of its release, and is made voluntarily on my part. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations. In addition, if this information is redisclosed by the recipient, it will also not be protected by federal privacy regulations.

I understand that my healthcare and the payment for my healthcare will not be affected by my signing this form. I further understand that I may see and copy the information described on this form if I ask for it, and that I will receive a copy of this form after I sign it. I have been informed that I may revoke this consent at any time within ninety (90) days except to the extent that action based on this consent has been taken. This consent will expire automatically after 90 days from the date on which it is signed, or upon the fulfillment of the above purposes, or on:________________________

_________________________________   ________________   ___________________
Signature of Patient or Parent/Guardian   Date   Relationship to Patient

_________________________________   ________________   ID Verified__________
Signature of Witness   Date   (Staff Only)

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