Partners for Behavioral Health and Wellness
24800 Highpoint Road, Beachwood, OH 44122
Phone: 216.342.5496 FAX: 216.763.9700

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)