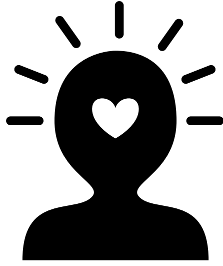


PsychMed Solutions, PLLC

Authorization to Release Confidential Records and Information

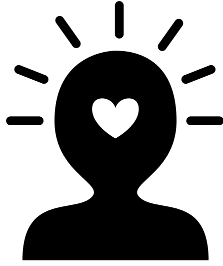
1. I understand that PsychMed Solutions, PLLC has an obligation to keep my personal information, identifying information, and my records confidential. I understand that I give permission for PsychMed Solutions, PLLC to release my personal information to certain individuals or agencies.

2. I ____________________________________ hereby authorize PsychMed Solutions, PLLC to send the records circled below.

    a. **A letter containing date of treatment(s) and a summary of service**
    b. **Intake paperwork completed by client at admission**
    c. **Summary of dates attended treatment at PsychMed Solutions, PLLC**
    d. **Billing history**
    e. **Progress notes**
    f. **Other:** ____
    g. **No documents to be sent; only verbal information specified below to be shared:** ____
    ____

3. The information may be shared (circle all that apply):
    a. In Person   By Phone   By fax   By mail   By email

    **I understand that electronic mail (email) is not confidential and can be intercepted and read by other people.*



PsychMed Solutions, PLLC

4. I understand that the above requested record will be sent to the identified agent/person below and this is accurate identifying information about me/the client (s)
    a. Name/Agency: ____
    b. Address: ____
    c. Phone: _______________________________Fax: ____________________

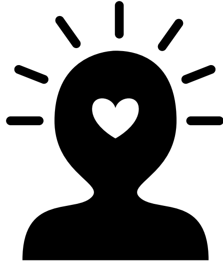
5. Why I want this information shared:
____
____
____

6. Please Note: *There is a risk that a limited release of information can open up access to by others to all of your confidential information held by PsychMed Solutions, PLLC.*

7. By signing below I understand:
    a. That I am not obligated to sign a release form. I do not have to allow PsychMed Solutions, PLLC to share my information. Signing a release form is completely voluntary. That this release is limited to what I write above. If I would like PsychMed Solutions, PLLC to release information about me in the future, I will need to sign another written, time limited release.

    b. That releasing information about me could give another agency or person information about my location and would confirm that I have been receiving services from PsychMed Solutions, PLLC.

    c. That PsychMed Solutions, PLLC and I may not be able to control what happens to my information once it has been released to the above person/agency, and that the agency or person getting my information may be required by law or practice to share it with others.



PsychMed Solutions, PLLC

8. This release expires on ______________________________________.
   **Expiration is to meet the needs of the client and is typically no more than 15-30 days, but may be shorter or longer.*

9. I understand this release is valid and when I sign it that I may withdraw my consent to this release at any time in writing.

Client Signature: ____Date: ______________

10. I, a mental health professional, have discussed the issues above with the client. My observations of behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

Provider Signature: _____________________________________Date: ______________________

This request/authorization to release confidential information is being made in compliance with the terms of the Privacy Act of 1974 (Public Law 93-579) and the Freedom of Information Act of 1974 (Public Law 93-502); and pursuant to Federal Rule of Evidence 1158 (Inspection and Copying of Records upon Patient's Written Authorization). It is in compliance with the Health Insurance Portability and Accountability Act (HIPPAA) of 1996, Public Law 104-191.