Morgan Hill Psychiatry, Inc.

RELEASE OF INFORMATION FORM

CONSENT TO RELEASE AND OBTAIN CONFIDENTIAL INFORMATION

PATIENT NAME: ____

DOB: ____________________________
SSN:____

I, ____________________________________, authorize Jafferany Psychiatric Services (JPS) to disclose and/or obtain information as described below (Please initial on line for information to be disclosed/obtained):

_____ Diagnosis _____ Psychiatric Evaluation _____ Demographic Information _____ All Information

Form of disclosure: Information may be disclosed by _____ Phone _____ Fax _____ Mail _____ All

Purpose: The purpose of this disclosure of information is to improve assessment and treatment planning, sharing information relevant to treatment, and when appropriate, coordinate treatment services.

If other purpose, please specify: ____

Expiration: Specify date, event or condition of expiration. If expiration is not specified, this authorization will automatically expire one year from date of signature: Specific date of expiration: ___________________________

Revocation: I understand that I have a right to revoke this authorization at any time by 1) sending written notification of Michigan Behavioral Health Institute; 2) giving verbal permission via telephone (JPS will ask for specific identifying information from you); 3) in-person request (sign and date Revocation Form).

To the following individual(s) and organization:

Name or the title of the organization to whom this information is to be released:

____
_______________ Address: _________________________ City: ________________________
State: ___________________________ Zip Code: ________________________ Telephone
Number: ____

I hereby authorize and request the release of information contained in my medical record including information about communicable disease and infection which includes Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), and AIDS Related Complex (ARC); and including substance abuse treatment records protected under the regulations in (Code 42 of Federal Regulations); psychological and social service records including communication made by the social worker, licensed professional counselor, psychologist, or psychiatrist, if any, to the individuals or organizations listed below.

_____ Medication

_____ Therapy Assessment

_____ Progress In Treatment

_____ Other: ____

_____ Treatment Plan

_____ Discharge/Transfer Summary _____ Participation In Treatment

I hereby release Jafferany Psychiatric Services and its staff from all legal responsibility that may arise from the release of the above information and/or these records. This release will expire on ________ or when it's purpose has been met or sooner at my election. It shall not remain in effect for longer than one year. I understand that I have the right to withdraw this authorization. Such a withdrawal must be in writing. I understand that JPS may not condition my treatment on whether

I sign a consent form, but that in certain limited circumstances I may be denied treatment if I do not sign a consent form.

Patient Signature ___________________________ Date _______________________________
Parent/Guardian Signature ____________________Date _______________________________

Witness Signature ___________________________Date _______________________________