Transitions Center
Psychiatry & Addiction Medicine

Release of Records

Note: Transitions Center MAY NOT release Mental Health Records directly to a patient without areview of the request and permissionby the Provider (please ask for Request to Personally Obtain Mental Health Records Form).

I hereby authorize _____ to release information from the records of

_____ (Patient Name) who has the following D.O.B ____/____/_____.

The information to be released is:

Psychiatric Evaluation _____ Medical History ____ Social History ____

Discharge Summary ____ Course of Treatment ____ Lab Reports ____

Medications ____ Developmental History ____ Academic Records ____

Attendance Records ____ Treatment Recommendations ____

Psychiatric/Neurologic/Psychologic Test Results ____

Other: _____

Records are requested for the purpose of: _____

Do Not Release

HIV ____ Drug/Alcohol ____

I understand that this authorization is effective for a period of one year from the date of signature, unless otherwise specified below. No time frame may exceed one year from the date of signature. I understand that I have the right to revoke this authorization at any time by sending a written request to the person I authorized above to release the information. If applicable, specify another expiration date here:

Signature: _____ Date: ____/____/_____

Please forward information to:

_____ (Facility or Person)

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: (_____) _____-_____ Fax Number (_____) _____-_____

I have been told that in order to protect the limited confidentiality of records, my agreement to obtain or release is necessary and that this permission is limited for the purposes and to the entity listed above, and will be effective during the date listed below. I also understand that this consent is revocable except to the extent that records have been sent.

This consent shall be in effect from: _____ until _____.

Patient/Guardian Signature: _____.

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Request to Personally Obtain Mental Health Records

I, _____ (Patient Name), am formally requesting a copy of my Mental Health Records from Transitions Center. I am requesting my records for the following reason(s):

_____

_____

_____

_____

_____ I agree to speak with my provider and discuss the reason for obtaining my records.

_____ I understand that my provider may deny my request to release my records to me.

Patient Signature: _____ Date: ____/____/_____

Provider Comments:

_____

_____

_____

_____

Provider Signature: _____ Date: ____/____/_____