# Release Of Information

CEH
CENTER FOR EMOTIONAL HEALTH®

**Patient Information:**

First Name: _____ Last Name: _____

DOB: _____ Phone Number: _____

Address: _____

City: _____ State: _____ Zip: _____

**I authorize the following individual or organization to receive my protected health information:**

Name: _____

Relationship to Patient (if applicable): _____

Phone Number: _____ Fax Number: _____

Email: _____

Address: _____

City: _____ State: _____ Zip: _____

**Information To Be Released (check all that apply):**

- ☐ All patient records
- ☐ Treatment Notes / Progress Notes
- ☐ Medication List
- ☐ Lab Results
- ☐ Other (please specify): _____

**Purpose of Disclosure:**

- ☐ Continuity of Care
- ☐ Insurance/Billing
- ☐ Legal Purpose
- ☐ Other: _____

**Method of Disclosure:**

- ☐ Verbal Communication
- ☐ Fax
- ☐ Mail

**Expiration of Authorization - This authorization will expired:**

- ☐ On the following date: _____/_____/_____
- ☐ One (1) year from the date of signature

By signing this form, I authorize the release of my protected health information as described above. I understand that:

- I may revoke this authorization verbally or in writing at anytime, except to the extent that action has already been taken in reliance on it.
- Information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected under HIPAA.
- This authorization does not grant the authorized individual(s) any right to make medical mental health, financial, or legal decisions on my behalf.

X_____ X_____

Signature of Patient Date