CEH
CENTER FOR EMOTIONAL HEALTH®

Release of Information

Acknowledgement: release of Information forms do not permit a person to make decisions for a patient. If someone other than the legal guardian is going to bring the patient to an appointment, the parents can fill out a release of information form but will also need to consent to the attending party making decisions in place of the parent.
It is in the best interest of the both the patient and parents for the parent to attend at least the first appointment so that they may provide approval moving forward.

Patient Name _____ Patient DOB _____

Street Address: _____ Telephone: _____

City, State, Zip: _____ Email: _____

Release Information From:

Name of Office: _____

Address: _____

Phone: _____

Fax: _____

Release Information To:

Name of Office: _____

Address: _____

Phone: _____

Fax: _____

Please check all that may apply to what you want to be released:

- ☐ Office Visits/Progress Notes
- ☐ Entire Patient Records
- ☐ Comprehensive Clinical Assessment
- ☐ Laboratory Reports, Medications, Other_____

Please Check one:

- ☐ Verbal Communication (Phone)
- ☐ Written Communication (Email)
- ☐ Actual Records Released

Purpose of Release:

- ☐ Continued Patient Care
- ☐ Legal Purpose
- ☐ Insurance
- ☐ Other:_____

This form is valid until:_____ (if no date inserted, it is valid 1 year from the date signed below.)

Patient Rights- I Understand that: I understand that I have a right to revoke this authorization at any time by notifying the medical records department of the above named organization in writing. I understand that revocation will not apply to information that has already been released in response to this authorization. I understand that I may request to inspect or obtain a copy of this information to be used or disclosed. I understand that my treatment cannot be conditioned on sighing this authorization unless I am being treated so that a third party can receive my health information, such as employer for a return to walk evaluation or insurance company for eligibility. If the patient is a minor, a parent or guardian must sign. I understand this permission is valid 1 year after the date of my signature unless otherwise noted.

- ☐ I acknowledge and hereby consent that the released information ay contain alcohol, drug abuse, psychiatric, HIV results or AIDS information.
- ☐ I authorize the release of any records regarding drug, alcohol or mental health treatment to the person listed above.

X_____ _____
Signature Relation to patient

X_____ X_____
Print Name Date