# Stephens Psychiatry

Dr. Jeff Stephens | Dr. Mary Ladd | Cara Reeves, PhD

## Authorization for Release of Medical Records

**Patient Name:** _____ **DOB:** ____/____/____ **Age:** _____

| | |
|---|---|
| **Release Records to:** (Where do you want the information sent? Who may have the information?) | Name of Individual/healthcare provider/hospital/practice: _____ Phone: _____ Fax: _____ |
| **Obtain Records From:** (Who has the information you want released? Please list the specific doctor/therapist and practice) | Name of Individual/healthcare provider/hospital/practice: _____ Phone: _____ Fax: _____ |
| **Purpose of Release:** (Why is it needed) | ☐ Continuing Care<br>☐ Legal, Disability, Insurance purposes<br>☐ School<br>☐ Patients Request |
| **Treatment Dates to be Released:** | ☐ Treatment dates from _____ to _____ (be specific)<br>☐ All treatment dates |
| **Family/Friends/Caregivers:** (please list all that we would have permission to speak with, including BOTH parents) | 1. Name: _____ Relationship: _____ Phone: _____<br>2. Name: _____ Relationship: _____ Phone: _____<br>3. Name: _____ Relationship: _____ Phone: _____ |

I understand this authorization may be revoked at any time, either verbally or in writing except to the extent that action has been taken in reliance on it. This consent will last while I am being treated for opioid dependence by the physician specified, unless the physician specified above is otherwise notified by me.

I understand that the records to be released may contain information pertaining to the psychiatric treatment and/or treatment for alcohol and/or drug dependency. These records may also contain confidential information about communicable diseases including HIV (AIDS) or related illness. I understand that these records are protected by the Code of Federal Regulations Title 42 Part 2 (42CFR Part2) which prohibits the recipient of these records from making any further disclosures to third parties without the express written consent of the patient.

| _____ | _____ | _____ |
|---|---|---|
| Signature of Patient/Guardian | Patient Name (Print) | Date |
| _____ | _____ | _____ |
| Signature of Witness | Witness Name (Print) | Date |