GEENENS PSYCHIATRY

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Last Name: _____ First Name:_____ MI:____ DOB:____/____/____

Address:_____ City:_____ State:_____ Zip Code:_____

Email Address:_____ Phone Number:_____

I authorize the release of my medical/psychiatric records from:

Name of Facility:_____ Phone Number:_____

Address:_____ City:_____ State:_____ Zip Code:_____

Fax Number:_____ Email Address:_____

I authorize the following individual(s) access to information regarding my time as a patient of Geenens Psychiatry:

Name:_____ Relationship:_____ Phone Number:_____

Name:_____ Relationship:_____ Phone Number:_____

Name:_____ Relationship:_____ Phone Number:_____

Name:_____ Relationship:_____ Phone Number:_____

Name:_____ Relationship:_____ Phone Number:_____

By signing this authorization form:

I authorize confidential Release of Medical Information about me by Geenens Psychiatry by releasing a copy of my medical records, or by a summary/narrative of my psychiatric information to the facilities/physicians/individuals listed above.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present it to Geenens Psychiatry administrative staff in person or via email. Revocation will not apply to information that has already been released in response to this authorization. I certify that a photocopy of this authorization is as valid as the original.

I acknowledge and certify that I am indeed the individual signing this authorization. Falsifying a signature is fraud and is punishable by federal law.

Printed Name of Patient/Authorized Representative: _____ _____

Patient/Authorized Representative Signature: _____ _____

Relationship to Patient (If applicable): _____ _____