Authorization for Release of Medical Information

Patient details

Last name, First name: _____ MI: _____ DOB: _____

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

Phone number: _____ Email: _____

I hereby authorize the release of my medical records from:

Name of facility: _____ Phone number: _____

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

Fax number: _____ Email: _____

I hereby authorize the following person(s) access to information related to my care by Marissa Lahey Psychiatry:

Name: _____ Relationship: _____ Phone number: _____

Name: _____ Relationship: _____ Phone number: _____

Name: _____ Relationship: _____ Phone number: _____

Name: _____ Relationship: _____ Phone number: _____

By signing this document:

I agree that Marissa Lahey Psychiatry is permitted to release confidential information pertaining to my care. This may include releasing a copy of my medical records or a summary of my psychiatric information to the facilities/persons listed above.

I am aware that include have a right to revoke this authorization at any time. I understand that to revoke authorization, I must present a written request to the office in person or via email. This revocation does not apply to the information which had already been released following this authorization. I confirm that a photocopy of this authorization may be substituted for the original with the same effect.

I acknowledge and confirm that I am in fact the person whose signature appears below.

Signature of the patient (or authorized representative): _____ Date: _____

Printed name of the patient (or authorized representative): _____

Relationship to patient (if applicable): _____

Please email the completed form to aprn@marissalahey.org or fax to 913-408-2670