Authorization for Release of Information
GENERAL

Patient Name: ____

Client ID: ______________ Admission Date: ________/________/________

Address: ____

Date of Birth: ________-________-________ Social Security Number: ________-________-________

Telephone Number: ( ) ________-________ Email:

I, ________________________ hereby authorize Saint John Vianney Center, to release to/obtain the following specific information on myself, by mail or telephone contact. The information contained in my Medical Record may include treatment of physical and/or mental health, treatment of chemical dependency and/or alcohol abuse, or testing or treatment of communicable or infectious diseases, tuberculosis, hepatitis, etc. Please check specific information and note exclusions requested:

- ☐ Admission Psychiatric Evaluation
- ☐ Treatment Narrative
- ☐ Verbal Communication
  - ☐ *Scheduling*
  - ☐ *Treatment Progress*
  - ☐ *Discharge Planning*
  - ☐ *Medical/Psychiatric Emergencies*
- ☐ Comprehensive Inpatient Evaluation
- ☐ Psychiatric Discharge Summary
- ☐ TeleHealth Video Conferencing
- ☐ Treatment Plan
- ☐ Other: ______________

(Please Specify) ____

This information is needed for the purpose of: ____

The information is to be released To / From (Circle One):

Name/Facility: ______________________________ Telephone: ( ) ________-________

Address: ____

This authorization is valid from ______-______-______ to ______-______-______ (may not exceed one year).
I have been informed that in order to protect the limited confidentiality of records, my agreement to release information is necessary and that this permission is limited for the purposes and to the persons listed above, and will be effective only during the dates listed above. I understand I will be told the name to whom and the dates when the information will be sent. I understand that this authorization, except for actions already taken, may be revoked by me at any time by communication to the Medical Records Department (written or verbal). I also understand that I may ask to see the information that is to be sent.

Patient has been offered a copy of this consent form ( ) Yes. Initials____________.

______________________________ ______-______-______
Patient Signature **Date**

______________________________ ______-______-______
Staff/Witness Signature **Date**

Revised: 7/24/2017