Family Psychiatry & Psychology Associates, P.A.

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RELEASE OF INFORMATION

I, (name of person signing form) , consent to allow all clinicians of Family Psychiatry and Psychology Associates, P.A. listed above to release and/or exchange information regarding

(your signature here) _____ (your date of birth) _____

Patient Name *Date of Birth*

This information will include: (check appropriate boxes for types of information to be shared)

- ☐ Psychiatric Records
- ☐ Procedures
- ☐ Medical Records
- ☐ Educational Records
- ☐ Discharge Summary
- ☐ Psychological Testing
- ☐ Therapy Notes
- ☐ Laboratory Work
- ☐ Other _____
- ☐ All of the above

Information can be shared with the following people/agencies (please include address):

(names, addresses, and/or phone numbers of people with whom information may be shared)

I understand that this information will be used in the client's best interests to benefit current psychiatric and psychological evaluation and/or treatment. I understand that the information exchanged will be handled in a professional and confidential manner.

It is the policy of FPPA not to release those materials provided by physicians from outside this office regarding the patient's former or current care. You may obtain second party records by contacting the source directly. Second party records will only be released when such records are no longer available from the original source.

I also understand that I may revoke this consent at any time except to the extent that action based on this consent has already taken place.

(sign form here) _____ (have a witness sign form here) _____

Signature *Witness*

(relationship to patient of who signed above) _____ (today's date) _____

Relationship to Client *Date*

This consent is valid until (optional - or indicate a date) . If I fail to specify an expiration date, this authorization will automatically expire 12 months from the date of signature.

Rescind Consent: I hereby rescind the prior consent granted to Family Psychiatry and Psychology Associates, P.A. to release and/or discuss any information with the individual(s)/agencies listed above.

(only sign to rescind consent - not required) _____ _____

Patient Name *Date*