MENTAL HEALTH WELLNESS CENTER

REQUEST FOR RELEASE OF BEHAVIORAL HEALTH RECORDS

CMG Mental Health Wellness Center • 2318 8th Street • Lewiston, ID 83501
Tel: (208) 746-1383 • Fax: (833) 941-3874

Patient Name: _____ Patient Date of Birth: _____

Patient Phone Number: _____ Appointment Date: _____

I HEREBY REQUEST AND AUTHORIZE YOU TO FURNISH ALL THE REQUESTED INFORMATION:

	RECORDS FROM:	**RECORDS TO:**
Provider or Group Name:		
Mailing Address:		
City, State and Zip Code:		
Phone and Fax Number:		

THE INFORMATION I REQUEST TO BE RELEASED IS:

❑ Medical records concerning the patient's care during the relevant time period, including:

- Inpatient or outpatient treatment records for physical and/or psychological, psychiatric, or emotional illness or drug and/or alcohol abuse.
- Admission and discharge summaries.
- Psychological or psychiatric evaluation(s), reports, assessments, treatment notes, summaries, or other documents with diagnoses, prognoses, recommendations, or testing records, and behavioral observations or checklists completed by any staff member or the patient, or similar documents.
- Treatment, recovery, rehabilitation, aftercare plans, and other similar plans.
- Social, family, educational, and vocational histories.
- Progress, nursing, case, or similar notes.
- Evaluations and reports of consultants.
- Information about how the patient's condition(s) affects or has affected his or her ability to work and to complete tasks or activities of daily living.
- Billing records.
- Academic and educational records, including achievement and other tests' results, reports of teachers' observations, and all other school or special education documents.
- HIV-related information and drug and alcohol information contained in these records will be released under this authorization unless indicated below under section "Do not release this information".

DO NOT RELEASE THIS INFORMATION:

❑ Complete copy of the medical record. ❑ Other, please list: _____

PURPOSE – PRACTICE MAY USE OR DISCLOSE THE INFORMATION FOR THE FOLLOWING PURPOSE(S):

❑ The disclosure is made at the patient's request. ❑ For a potential or pending legal action.

❑ Other: _____

THE TIME PERIOD OF RECORDS THAT I REQUEST TO BE RELEASED IS:

❑ All Records ❑ From: _____ To: _____

ACKNOWLEDGEMENT OF UNDERSTANDING:

- I understand that my records may contain information regarding the diagnosis or treatment of HIV (AIDS virus), other sexually transmitted diseases, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.
- I understand and agree that this authorization will be valid and in effect for **90-days** from the date it is signed below.
- I understand that I may revoke this authorization at any time by notifying the providing organization in writing and it will be in effect on the date notified except to the extent action has already been taken.
- I understand that by authorizing this use or disclosure of information, there will be no conditions placed on my care or payment for my care.
- I understand that I may inspect and have a copy of the information described in this authorization.
- I understand that Catalyst Medical Group, PLLC cannot limit or control the subsequent use or dissemination of medical information by the party to whom I request the information be furnished. This request is a free and voluntary act by me. I hereby release Catalyst Medical Group, PLLC and its staff from all legal responsibility that may arise from the release of medical information hereby authorized.

There is no charge when records are sent to a physician for continuing care. A copying fee is charged when records are released to a patient or other non-physician recipient. The copy charge is required cash day of service. Please allow 30 working days for copying and preparation of records.

⌦ Parent/Guardian Signature: _____ Date: _____

⌦ Patient Signature: _____ Date: _____

Would you like to receive the requested information in an electronic format? (CD vs. paper?) ❑ YES ❑ NO

OFFICE USE ONLY | AUTHORIZATION IS VALID FOR 90-DAYS
Give a copy of the authorization to the patient or personal representative

Expiration Date: _____
Staff Initials: _____