AUTHORIZATION FOR RELEASE OF PSYCHIATRIC RECORDS
(Please Print)

Psychiatry Associates of Tupelo

Patient Name_____ Date of Birth_____
Address_____
_____
Daytime Phone Number_____

I hereby authorize my physician(s) and/or administrative and clinical staff at

_____
_____

to disclose the protected health information described below to:

Name_____ Mail_____
Address_____ Pick Up_____

Information To be released _____ All Psychiatric Records
_____ ONLY the information described as Follows_____

(NOTE: A fee may be charged for providing your records.**)** _____
_____

This protected health information is to be disclosed for the following purpose: _____
_____

I understand that my physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits on whether I provide authorization for a requested disclosure except if health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Privacy Contact of the practice I authorized above to disclose the specified protected health information. I understand that a revocation is not effective to the extent that action has already been taken in reliance on the authorization or during an insurance claim contestability period if my authorization was obtained as a condition of obtaining insurance coverage.

I understand that a photocopy of this authorization shall have the same force and effect as the original authorization.

I understand that information disclosed pursuant to this authorization may be re-disclosed by the recipient and may no longer be protected by federal or state law.

EXPIRATION DATE: This authorization is valid until _____, at which time this authorization to disclose this protected health information will expire. If no expiration date is indicated above, I understand that this authorization will be valid for ninety (90) days from the date signed.

_____ _____
Signature of Patient/Legal Representative Date

_____
Relationship to Patient

_____ _____
Witness Date

1040 B South Madison St. ▪ Tupelo, MS 38801 Phone (662) 844-4364 ▪ Fax (662) 844-4365