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REQUEST AND AUTHORIZATION TO RELEASE RECORDS AND INFORMATION

I, _____, born on _____ authorize
Patient Name (Please Print)

___ **Release/Disclose Protected Health Information To:**

Name: _____

Relationship to Patient: _____

Address: _____

_____

Phone: _____ Fax: _____

__ **Obtain Protected Health Information From:**

Name: _____._____

Relationship to Patient: _____

Address: _____

_____

Phone: _____ Fax: _____

This authorization includes release of records pertaining to: (Check all that Apply)

____ Mental Health ____ Chemical Dependency Abuse Treatment ____ HIV/AIDS
____ Diagnosis or treatment related to other communicable diseases _____ Medical Records

This authorization and request to release or obtain information from my records is fully understood as to the nature of the records and information and the implications of its release, and is made voluntarily on my part. I understand that if the organization authorized to receive the information is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations. In addition, if this information is redisclosed by the recipient, it will also not be protected by federal privacy regulations.

I understand that my healthcare and the payment for my healthcare will not be affected by my signing this form. I further understand that I may see and copy the information described on this form if I ask for it, and that I will receive a copy of this form after I sign it. I have been informed that I may revoke this consent at any time within ninety (90) days except to the extent that action based on this consent has been taken. This consent will expire automatically after 90 days from this date of authorization unless revoked by me, or my legal representative, through written notification to the Thomas A. Boyd, Psy.D. at 21625 Chagrin Blvd., Beachwood, OH 44122, or upon the fulfillment of the above purposes, or on: _____. Any revocation will not apply to information released prior to receiving the written notification of revocation.

_____ _____ _____
Signature of Patient or Guardian Date Relationship to Patient

_____ _____ ☐ Identification Verified
Signature of Witness Date