MERIDIAN
PSYCHOTHERAPY SERVICES LLC

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize: _____
Name of institution (releasing information)

_____
Address

to release psychiatric records (including drug and/or alcohol records) regarding:

_____ _____ _____
Name of Patient Social Security Number Date of Birth

to: _____
Name of institution (receiving information)

_____
Address

for the purpose of:_____

Dates of Treatment:_____

Specific information to be released:

_____Discharge Summary	_____History and Physical	_____Other (Specify)_____
_____Progress Notes	_____Laboratory Reports	_____
_____X-Ray Reports	_____Admission Note	_____
_____Medications	_____Psychological Assessment	_____

I understand that the confidentiality of drug and alcohol abuse patient records maintained by this office is protected by Federal Law 42 CFR Part 2. This information will not be released without my permission. This authorization may be revoked at any time, except to the extent that action has been taken in reliance on it. If not previously revoked or otherwise specified, this information will expire six months from the date of signature of the patient.

_____
Expiration Date

This authorization may be relied upon when transmitted by facsimile _____Yes _____No
I further authorize the information to be sent by facsimile _____ Yes _____No
I agree to hold this office harmless if my medical information which is transmitted by facsimile does not reach the appropriate authorized recipient. _____ Yes _____No

_____ _____
Signature of Patient Date

_____ _____
Signature of Legal Guardian Witness
If patient is under guardianship, proof of court-appointed guardianship is required.

"ANY DISCLOSURE OF MEDICAL RECORD INFORMATION BY THE RECIPIENT(S) IS PROHIBITED, EXCEPT WHEN IMPLICIT IN THE PURPOSES OF THIS DISCLOSURE."

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