Department of Psychiatry
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Authorization to Release and Disclose Patient Information

PATIENT INFORMATION TTUHSC MRN:_____	PATIENT NAME: _____ DATE OF BIRTH:_____ Address:_____ Day Phone:_____ City:_____ State:_____ Zip:_____
RECEIVING PARTY ☐ Send the information to: ☐ Receive the information from:	NAME:_____ Address:_____ Phone:_____ City:_____ State:_____ Zip:_____
INFORMATION TO BE RELEASED (What do you want sent or released? Check the appropriate box.)	☐Any and All records (complete record) Only records types checked below : ☐Progress notes/clinic notes ☐Schedule ☐Laboratory reports ☐Other (please specify)_____ ☐Immunization record ☐Billing Records (date s) _____ ☐Medication record ☐Routine Record Set (indicate date(s) of service_____) ☐Schedule (office visit, lab, radiology, medicines, immunizations) I agree that the following information may be released/used only as indicated below: 1. AIDS/HIV test results, diagnosis, treatment, and related information Yes No 2. Drug screen results and information about drug and alcohol use and treatment Yes No 3. Mental health information Yes No 4. Genetic testing Yes No
RELEASE INSTRUCTIONS (How do you want the information?)	☐ Electronic Form (CD/USB preferred method) ☐Paper
PURPOSE OF RELEASE (Why is it needed?)	☐Continuing Care by other health care provider ☐Disability ☐School ☐Insurance ☐Personal review ☐Attorney/Legal ☐Other_____
To The Receiving Party Of This Information	This information has been disclosed to you for the sole purpose(s) stated in this Authorization. Any other use of this information without the express written consent of the patient is prohibited. These records may be protected by federal regulation. Federal rules prohibit you from further disclosure

I certify that this form has been fully explained to me, I have read it or had it read to me*, and I understand its contents.

Date Print Your Name (Person signing consent form) Patient or Legally Authorized Signature

Time Witness/Translator * Relationship to patient