Stephens Psychiatry

Jeff Stephens, MD | Cara Reeves, PhD

Authorization for Release of Information

Patient Name: ______ **Date of Birth:** ______

Release/Obtain Records: (Who/Where we may receive/release records)	**Name of Individual/healthcare provider/hospital/practice:** ______ Phone: ______ Fax: ______
Purpose of Release: (Why is it needed):	☐ Continuity of care ☐ Patient's request ☐ Legal, disability, insurance purposes ☐ Other
Types of Records (What can be released?)	☐ All Records ☐ Mental health evaluations ☐ Developmental and/or social history ☐ Progress Notes, and treatment summary ☐ Other
Treatment Dates to be Released:	☐ All Treatment Dates ☐ Treatment Dates from ______ to ______
Family/Friends/ Caregivers: (please list all that we would have permission to speak with, including BOTH parents)	1. Name: ______ Relationship: ______ Phone: ______ 2. Name: ______ Relationship: ______ Phone: ______ 3. ☐ **Release my information to no one other than myself.**

Please read and check the following before signing:

☐ I understand this authorization may be revoked at any time, either verbally or in writing except to the extent that action has been taken in reliance on it. This consent will last while I am being treated for opioid dependence by the physician specified, unless the physician specified above is otherwise notified by me.

☐ I understand that the records to be released may contain information pertaining to the psychiatric treatment and/or treatment for alcohol and/or drug dependency. These records may also contain confidential information about communicable diseases including HIV (AIDS) or related illness. I understand that these records are protected by the Code of Federal Regulations Title 42 Part 2 (42CFR Part2) which prohibits the recipient of these records from making any further disclosures to third parties without the express written consent of the patient.

Signature: ______________________________ **Date:** ______

Relationship to Patient: ______ **Name of Authorized Representative:** ______

If you are returning records to Dr. Stephens or Dr. Reeves, **please fax them to 864-520-1124.**