



# Comprehensive MedPsych Systems, Inc.

## AUTHORIZATION FOR EXCHANGE/RELEASE OF INFORMATION

DO NOT RELEASE INFORMATION IF THIS AUTHORIZATION IS NOT COMPLETELY FILLED OUT-BLANKS MUST BE COMPLETED

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_ Date of Birth \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ SS# \_\_\_\_\_

Home Telephone Number \_\_\_\_\_ Work Telephone Number \_\_\_\_\_

- I authorize the use or disclosure or exchange of the above named individual's health information as described below:
- The following individual or organization is authorized to obtain, disclose or exchange information:  
Name: \_\_\_\_\_, Comprehensive MedPsych Systems, Inc.  
Address: 1229 South Tamiami Trail, Sarasota, FL 34239

3. The type of information to be used or disclosed or exchanged is as follows: (include dates where appropriate)

- |   |  |
|---|--|
| <input type="checkbox"/> Intake Summary – date(s) _____       | <input type="checkbox"/> Psychological treatment summary – date(s) _____   |
| <input type="checkbox"/> Termination Summary – date(s) _____  | <input type="checkbox"/> Psychotherapy Notes – date(s) _____               |
| <input type="checkbox"/> History & Physical – date(s) _____   | <input type="checkbox"/> Psychological/Educational Testing – date(s) _____ |
| <input type="checkbox"/> Discharge Summary – date(s) _____    | <input type="checkbox"/> Consultation Reports – date(s) _____              |
| <input type="checkbox"/> X-ray/CT/MRI Reports – date(s) _____ | <input type="checkbox"/> Emergency Room Record – date(s) _____             |
| <input type="checkbox"/> Other _____                          |  |

4. If this authorization is for release of medical records, I understand that I am giving my permission to release copies of information in my medical record that may include information relating to psychiatric treatment, drug/alcohol treatment, AIDS/HIV testing or treatment of sexually transmitted disease unless indicated in the following instructions: \_\_\_\_\_

5. This information may be obtained by or disclosed to the following individuals or organizations:

Name _____	Name _____	Name _____
Address _____	Address _____	Address _____
Tel. _____ Fax _____	Tel. _____ Fax _____	Tel. _____ Fax _____

I wish for treatment information to be shared with my primary care physician: YES or NO (please circle) Name: \_\_\_\_\_

Information is to be released for the purpose of: **at the request of the individual** and/or \_\_\_\_\_

- I understand that I have a right to revoke this authorization at any time. My revocation becomes effective when delivered in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization will expire one year from the date signed, unless an expiration date, event or condition is specified as follows: \_\_\_\_\_
- I understand that the information disclosed to the above individual or organization may be redisclosed and not be protected by the federal Privacy Rule.
- I understand that the authorized health care provider cannot condition his/her providing of health care on whether or not I sign this authorization, unless I am requesting care specifically for it to be disclosed under this authorization (for example, a physical for school enrollment).
- I understand there may be a fee of up to \$1.00 per page if I request copies for individuals or organizations.

\_\_\_\_\_  
Signature of Patient or Legal Representative      Print Name      Date

\_\_\_\_\_  
If Signed by Legal Representative, Describe Relationship and Authority to Act on Patient's Behalf