M. E.
PSYCHIATRIC CARE

M. E. Psychiatric Care Authorization for Release of Information

Patient Name _____

Date of Birth _____

Phone Number _____

I authorize:

M. E. Psychiatric Care

Mailing Address: 3523 45th St. S. Suite 100 Fargo, ND 58104. Phone: 701-203-5247/Fax: 701-203-2903

To Release to: _____Yes _____No

To Obtain from: _____Yes _____No

Name and/or Organization _____

Address _____

City, State, Zip Code _____

Phone Number _____

Fax Number _____

Email Address _____

How Information May Be Communicated: _____Written _____Fax _____Verbal

Dates of Documentation Being Requested: _____All Available or From _____to_____

Information to be Released and/or Obtained:

Psychiatric Evaluation ____Yes ____No

Labs/EKG/Imaging ____Yes _____No

Psychological/Neuropsychological Evaluation _____Yes _____No

and Physical ____Yes _____No

Progress Notes/Treatment Progress ____Yes _____No

Consults ____Yes ____No

Treatment Plan/Discharge Summary ____Yes _____No

Other _____ ____Yes ____No

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The information is necessary for:

Assessment and Treatment	____Yes _____No
Coordination and Follow-Up	____Yes _____No
Acknowledge Referral	____Yes _____No
Insurance Purposes	____Yes _____No
Legal Purposes	____Yes _____No

This Consent to Release Confidential Information remains in effect for five years from date signed for this information and date of service only. I understand that I may revoke this authorization in writing at any time, except where actions have already been taken in reliance on it.

I understand that authorizing the disclosure of this information is voluntary and I can refuse to sign this authorization. I further acknowledge that any disclosure of information carries with it the potential for re-disclosure and the information may not be protected by Federal confidentiality rules. Chemical Dependency records are further protected by a more stringent Federal Law (42 CFR Part 2). This information cannot be disclosed without the expressed authorization of the patient, nor can the information be redisclosed unless specifically authorized by the patient or as otherwise permitted by 42 CFR Part 2. I do not authorize further release to any third party and hereby release the hospital, clinic, and their employees and by provider(s) for any and all liability arising directly or indirectly from such a re-disclosure. A copy or fax of this authorization shall be as valid and may be used and relied upon with the same force and effect as the signed original document.

Any and all medical records including records relating to communicable diseases such as HIV, AIDs, and sexually transmitted diseases will be released unless otherwise indicated by placing patient/legal representative's initials here.

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Any and all medical records including records relating to mental health records or chemical dependency records will be released unless otherwise indicated by placing patient/legal representative's initials here.

____

x_____ Date_____

Signature of Patient or Parent/Guardian

_____

Expiration Date of Release (5 years)