GERMANTOWN PRIVATE PSYCHIATRY PLLC

Release of Information

I hereby authorize an exchange of the following protected information of:

Patient Name:____ D.O.B.______________

Between: Germantown Private Psychiatry PLLC and ______________________________________
7505 Capital Dr. ______________________________________
Germantown, TN 38138 ______________________________________
Phone: (901) 730-0575 Fax: (901) 730-0389 ______________________________________

PURPOSE OF RELEASE: Coordination of Care____

SPECIFIC INFORMATION TO BE RELEASED:

[ ] History and Physical
[ ] Psychiatric Records
[ ] Outpatient Treatment Notes
[ ] Phone Communication between parties
[ ] Social / Emotional / Academic Functioning at School
[ ] School Attendance Records
[ ] Psychological and / or Educational Evaluations
[ ] IEP Plans
[ ] Other (specify) ____

DATES: Covered by this authorization are from: __________________to_______________________

It is my understanding that this information will be used solely for the purpose described above. I understand that the information which I am authorizing to be released may include psychiatric diagnoses and or drug/alcohol related information. I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy rule. I understand that I may revoke my permission in writing at any time. Any actions Germantown Private Psychiatry PLLC may have taken before receiving notice that the consent has been revoked would not be covered by the revocation. I hereby release Germantown Private Psychiatry PLLC and its duly authorized agents from all legal responsibility or liability for the release of information indicated and authorized herein.

A duly signed and completed fax or photocopy of this form is considered valid.

Patient’s Name: _______________________________________ DOB: ___________________

Parent/Guardian Signature: ______________________________ Date: ___________________

Relation to Patient: [ ] Parent [ ] Legal Guardian [ ] Foster Parent [ ] Other _________________

Witness: ____ Date: ____________________