Ohio Psychiatry Specialists
4807 Rockside Rd. Ste. 300
Independence, OH 44131
P. 216.503.9489
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RELEASE OF INFORMATION AUTHORIZATION

By signing this form, I hereby authorize Ohio Psychiatry Specialists, LLC to:

_________ Release individual health care records

__________ Obtain individual health records

From/To: Name/Facility: ________________________________

Phone/Fax: _______________________________

Address: ________________________________

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I understand that this authorization extends to all or any part of the records/information designated below. This may include treatment for physical and mental illness, alcohol/drug abuse, HIV/AIDS test results or diagnoses.
The information released can be verbal or written and includes:

____ Medical Records

____ Psychiatric Evaluation

____ Discharge Summary

____ Consultation Report

____ Treatment Plan

____ Progress Notes

____ Laboratory/Imaging Data

____ Medication Records

The purpose of releasing this information is:

____ Continued Medical Treatment

____ Other: ________________________

I hereby release Ohio Psychiatry Specialists, LLC and the above-mentioned disclosing/receiving entity from all legal responsibilities or liability that may arise from the use or disclosure of medical records and/or other information.

Expiration: Valid indefinitely unless revoked or according to relevant state law.

Revocation: I understand I have the right to revoke this consent at any time in writing or verbally followed by in writing. Revocation takes effect at the date/time it is received and does not encompass information already released.

Refusal: I have the right to refuse to sign this form. Doing so may terminate treatment relationship.

__________________________ ____________ ________________________ ___________

Patient/Guardian Signature **Date** **Printed Name** **Date of Birth**