MAP
MERIDIAN ADVANCED PSYCHIATRY

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

This release allows Meridian Advanced Psychiatry to communicate/share/request your protected health information with any medical office or the individual(s) listed below.

Patients Name: _____ Birth Date: _____

Address: _____ Phone Number: _____

I, _____ authorize Meridian Advanced Psychiatry and the office/individual(s) listed on this form to communicate with and disclose to one another the following information indicated below:

Individual(s) to have access to my PHI and appointment information:

Name: _____ Relationship: _____
Name: _____ Relationship: _____

Please complete the information below if you need records released to another Medical Clinic.

Name of Medical Office: _____ Phone: _____ Fax: _____

Address: _____

Please mark which records you would like released to the above Clinic or Individual.

❑ Discharge Summary	❑ ER Report	❑ History & Physical
❑ Demographics	❑ X-Ray/Imaging Reports	❑ Reports & Evaluations
❑ Chart Notes	❑ Lab Results	❑ Medication List

❑ Complete Patient Record (including progress reports, chart notes, UA results, lab tests, TB tests, treatment plan, demographics, verification of funding source(s), and billing documentation)

❑ Other (Please Specify): _____

I understand that my mental health and substance use disorder records are protected under federal law, including the federal regulations governing the confidentiality of substance use disorder patient records,42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I understand that I may revoke this authorization at any time except to the extent that action has been taken in reliance on it. Unless I withdraw my consent earlier, this consent will expire automatically on the following date: _____

I understand that I might be denied services if I refuse to consent to disclosure for purposes of treatment, payment, or health care operations if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes. I acknowledge that the information to be released was fully explained to me, that this consent is given of my own free will, and that by signing, I have reviewed and understand the terms of this consent. I have been provided with a copy of this document.

Patient or legal representative signature: _____ Date: _____

Printed name of the individual signing this form: _____ Relation to Patient: _____

MAP Staff Only Date revoked: _____ Staff Initials: _____

❑ Release of records to Individual
❑ Release of records to Medical Office Name: _____