MAP
MERIDIAN ADVANCED PSYCHIATRY

CONSENT FOR RELEASE OF MEDICAL RECORD INFORMATION

MAP Contact: (P) 208-515-2273 | (F) 208-515-2274

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

Patient 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:

Check either or both as needed:

❑ Requesting Medical Records ❑ Releasing Medical Records

Name of Medical Office/Individual: _____

Phone: _____ Fax: _____

Address: _____

This request is valid for services covering:

FROM: ❑ Most Recent Visit ❑ Date Range: _____ to _____ ❑ Last 2 Years

Information to be Used or Disclosed:

❑ 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): _____

Please indicate format(s) for releasing and/or requesting information:

❑ Publish to my Patient Portal ❑ Mail to address listed above ❑ Pick up ❑ Faxed to number listed above

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.

I understand that I might be denied services if I refuse to consent to a 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 and 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.

**This Release is effective from the date signed and will expire in 12 months unless specified otherwise:* _____

Patient or legal representative signature: _____ Date: _____

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

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**** MAP STAFF ONLY ****

Date revoked: _____ Staff initials: _____

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