

RELEASE OF INFORMATION REQUEST FORM

DISCLOSURE: I (patient's name), _____, hereby authorize Georgetown Behavioral Health Institute to release and discuss medical records, (including any information related to medical, surgical, psychological, social, psychiatric, drug and/or alcohol abuse, diagnosis, treatment, prognosis and/or therapy) therein contained. **Initial:** _____

Please release any information **FROM:**

Please release information **TO:**

GBHI

 (Name)
3101 S. Austin Ave

 (Address)
Georgetown TX 78626

 (City) (State) (Zip)

 (Name)

 (Address)

 (City) (State) (Zip)

 (Secured FAX or Secured email)

Please allow 7-10 days for records to be released.

 (Phone)

Type of access requested: Inspection of medical record Copy of medical record Verbal exchange of information related to care only

To obtain copies of the medical record, check the appropriate box below:

Will pick-up medical record Mail medical record to the address above FAX to the number above e-mail to the address above

A charge for copies of medical record will be assessed, based on Texas copy allowance rule, when the request is for purpose other than care related.

I specifically need the following information released (requests for "any and all records" is NOT acceptable):

- Discharge Summary Psychiatric Evaluation History & Physical Physician Orders Medication Records
 Intake Assessment Psychosocial Evaluation Nursing Assessment Laboratory/X-ray Reports
 Other: _____ Entire Record (reason why): _____

The recipient of the information released may use it only for the following purposes (must be indicated)

- | | | |
|-----------------------------------|-----------------------------------|-----------------------|
| _____ Assessment & Evaluation | _____ Claims Settlement | _____ Personal Use |
| _____ Continued Care & Treatment | _____ Military | _____ Aid Entitlement |
| _____ Placement & Aftercare | _____ Health Insurance Enrollment | _____ Employer |
| _____ Legal Proceedings or Advice | _____ School/Educational Needs | _____ Verbal Exchange |
| OTHER: _____ | | |

The information authorized for release may include information which may be considered information about communicable or venereal diseases, which may include, but are not limited to, diseases such as Hepatitis, Syphilis, Gonorrhea, and the Human Immunodeficiency Virus, also known as Acquired Immune Deficiency Syndrome (AIDS). **Initial:** _____

I understand that my records are protected under the Federal regulations governing Confidentiality of Alcohol & Drug Abuse records (42 CFR, Part 2), and cannot be disclosed without my written consent unless otherwise provided for in the regulations. This consent is subject to revocation by the undersigned at any time except to the extent that action has been taken in reliance on it, **and unless further limited by the following date:** _____ will expire after a period of 90 days (3 months). I have a right to receive a copy of this authorization upon my request.

DATE	TIME	PATIENT SIGNATURE (IF SIXTEEN YEARS OR OLDER):	
RELATIONSHIP	TIME	RESPONSIBLE PARTY SIGNATURE	
RESPONSIBLE PARTY PHONE NO. HOME () - WORK () - CELL () -			
DATE	TIME	WITNESS SIGNATURE	TITLE
To be completed by GBHI:			
INFORMATION RELEASED FROM THE MEDICAL RECORD:			
<input type="checkbox"/> Discharge Summary <input type="checkbox"/> Psychiatric Evaluation <input type="checkbox"/> History & Physical <input type="checkbox"/> Physician Orders <input type="checkbox"/> Medication Records <input type="checkbox"/> Laboratory/X-ray Report <input type="checkbox"/> Nursing Assessment <input type="checkbox"/> Intake Assessment <input type="checkbox"/> Entire Record <input type="checkbox"/> Psychosocial Assessment <input type="checkbox"/> Other: _____			
Records copied by: _____		Date sent: _____	
Via: <input type="checkbox"/> U.S. Mail <input type="checkbox"/> Pick-up <input type="checkbox"/> Secure FAX <input type="checkbox"/> Secure e-mail			
Records given to: _____			
Faxed to phone number: () Attention: _____			