RELEASE OF INFORMATION REQUEST FORM

DISCLOSURE: I (patient's name/DOB),______________________________,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:

GBHI
(Name)
3101 S. Austin Ave
(Address)
Georgetown TX 78626
(City) (State) (Zip)

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

Please release information TO:

____
(Name)
____
(Address)
____
(City) (State) (Zip)
____
(Secured FAX or Secured email)
____
(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:** ______________________________ ☐List Record type(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: ☐Discharge Summary ☐Psychiatric Evaluation ☐History & Physical ☐Physician Orders ☐Medication Records ☐Laboratory/X-ray Report ☐Nursing Assessment ☐Intake Assessment ☐ Entire Record ☐Psychosocial Assessment ☐ Other: ______________________________

Records copied by: ______________________________ Date sent: ______________________________

Via: ☐ U.S. Mail ☐ Pick-up ☐ Secure FAX ☐Secure e-mail

Records given to: ______________________________

Faxed to phone number: (__________)______________________Attention: ______________________________

Patient Label