Coastal Behavioral Health LLC

Toni Richardi, Psy.D.

Release of Information Form

This form must be completed in its entirety to be considered valid.

Patient Name:_____ D.O.B:_____

SS#:_____-_____-_____)__ Phone #:_____

Release records to (include organization name) □ Obtain records from (include organization name) □	Name/Organization: _____ Address:_____ City:_____ State:_____ Zip:_____ Phone #:_____ Fax #:_____ Attention to:_____		
Release Instructions	Phone □ Fax □ E-mail □ _____ Mail □ Other □_____		
Purpose of Release	Patient Request □ Physician Referral for Evaluation □ Continuing Care □ School □ Military □ Legal □ Other □ _____ I understand that fees for copies of medical records and postage may be included.		
Dates of Treatment	□ From _____ to _____ □ All dates		
Information to be released	□ ENTIRE RECORD □ Immunization Records □ Medication List □ Physician progress/visit notes	□ Abstract Information (history& physical, medication list, lab reports, operative/procedure notes)	□ Psychological Evaluation/ Intake □ Psychological treatment summary □ Discharge summary □ Psychotherapy notes

I understand this information may include reference to psychiatric / psychological care, sexual assault, drug abuse, results of tests for all infectious diseases including HIV / AIDS and / or alcohol abuse.

I understand that I have a right to cancel / revoke this authorization at any time. I understand that if I cancel / revoke this authorization I must do so in writing and present my written cancellation / revocation to the Health Information Services Department (Medical Records). I understand that the cancellation / revocation will not apply to information that has already been released in response to this authorization, as stated in the Notice of Privacy Practice. Unless otherwise canceled / revoked, this authorization will expire / end **one year** from this date.

I understand that authorizing the disclosure of protected health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to receive treatment. I understand I may review and / or copy the information to be disclosed, as provided in 45 CFR §164.524. I understand that any disclosure of information carries with it the possibility of unauthorized disclosure by the person / organization receiving the information. I understand I will be given a copy of this authorization.

_____ _____

Patient Name (Printed) Date

_____ _____

Patient Signature (or parent/guardian) Relationship to patient

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