**PEACE OF MIND MENTAL HEALTH SERVICES, LLC**

**8614 Ocean Gateway, Suite 4**

**Easton, MD  21601**

**(410) 690-8181-phone (410) 690-8185-fax**

**RELEASE OF MEDICAL RECORDS**

This form when completed and signed by you, authorizes your provider to release protected information from your clinical record to our agency.

**Effective One year FROM:\_\_\_\_\_\_\_\_\_\_\_\_\_TO: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**PARTICIPANT’S NAME (Print):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I** **AUTHORIZE PEACE OF MIND MENTAL HEALTH SERVICES, LLC TO RELEASE and/or RECEIVE INFORMATION TO/FROM:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Specific Organization/Person                                     Address**

**INFORMATION THAT MAY BE RELEASED:**

\_\_\_Most Recent Physical Exam \_\_\_Immunizations Record \_\_\_Assessments

\_\_\_Labs \_\_\_Medication Log \_\_\_Diagnostic Tests

\_\_\_EKG \_\_\_Psychosocial Evaluations \_\_\_Discharge Summary

\_\_\_Psychological Evaluation \_\_\_Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REASON:** (   ) Provide continuity of care (   ) Compliance with program (  ) Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DATES OF SERVICE:  “Duration of treatment”**

I understand that my health information is protected under the federal regulations governing the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2 that re-disclosure is prohibited, 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 in the regulations.  The information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer will be protected by the HIPAA Privacy Law.

1. review and understand the Notice of Privacy Practices;
2. this authorization is subject to revocation at any time in writing, except to the extent that action has been taken in reliance on the authorization;
3. inspect and receive a copy of the material to be released;
4. request restrictions on how my health information is used and disclosed; and
5. receive a copy of this authorization and the Notice of Privacy Practices

This form has been fully explained and I certify that I understand its contents. I understand that POM may not condition treatment on obtaining this consent/authorization from me.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Participant’s Signature or Oral Consent when physically unable to sign    Date

                        “I understand the nature of the release and freely give oral consent”

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Authorized Person or Guradian Date

(   ) Power of Attorney; (   ) Guardianship Order

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness Signature Date   Oral Consent/Witness Signature Date