Ψ

SOUTHEAST PSYCHIATRY

RELEASE OF INFORMATION

I,_____ Date of Birth: _____

I hereby release_____ to disclose the following information to:

Southeast Psychiatry
2 Marine Way, Merchant Wharf Building Ste.204
Juneau, Alaska 99801
(907) 209-8962

Authorization by Fax to# 866-581-8172

Faxed Information will be limited to the following:

Please INITIAL next to the information you agree to release.

Diagnosis:	
Diagnostic Tests:	
Clinical History:	
Social History:	
Progress Notes:	
Consultations and Labs:	
Drug and Alcohol History:	
Prior Hospitalization:	

2 Marine Way Suite 204
Juneau, AK 99801
907-209-8962 fx 866-581-8172
www.sepsychiatry.com

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Other information to be released: (verbal contact and mutual release)

The purpose of this release of information is for continuity of care, diagnosis and treatment.

If I wish to review this information prior to release, I will initial here: _____

Please initial in the columns for each item you do or do not accept.

	I Do	I Do NOT	
1			authorize disclosure of information which refers to drug and alcohol abuse.
2			authorize disclosure of information which refers to treatment or diagnosis of a psychiatric illness.
3			authorize disclosure of information which refers to treatment or diagnosis of HIV infection, ARC, or Aids.
4			understand that the Provider will not condition treatment on signing this authorization. The Provider will not deny me care if I do not sign this form. I may review the record before signing. I may refuse to sign this form.
5			realize that I can revoke this authorization at any time, in writing.
6			release of information created at future visits will require additional authorization.
7			realize that I may have a copy of this form by asking the provider for one.
8			release the provider, and his/her employees, and covering practitioners from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

Signature of patient, or guardian Date: _____

_____ Expiration Date: _____

Signature of parent or minor or other responsible person Date: _____

_____

Witness: Capacity

_____ _____

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