Generations **P**sychiatry **S**ervices
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Authorization to Release Confidential Medical Information

I hereby authorize and/or request that the staff at Generations Psychiatry Services PLLC: (check applicable boxes)

Speak to: ☐

Obtain Records from: ☐ Dates:_____

Release Records to: ☐ Dates:_____

Name (s) of Individual (s) and/or Organization (s)

_____

_____

_____

Phone:_____ Fax:_____

I understand that this health information may include HIV-Related information relating to diagnosis and/or treatment of psychiatric disabilities and/or substance abuse and that by signing this form I am authorizing such information to be disclosed.

The disclosure of this information is necessary for the purpose of further treatment planning. I understand that I may revoke this authorization to release information at any time by giving written notice. I understand that any information released prior to my revoking this authorization shall not be a breach of my right to confidentiality.

Name:_____ Address: _____

Patient Date of Birth:_____ _____

City State Zip Code

Date Signed:_____

Signature of Patient/Guardian/Legal Representative_____