

PATIENT'S PERMISSION TO DISCLOSE INFORMATION

At Psychiatric Services, PC, we are committed to treating and using protected health information about you responsibly. Below are listed ways in which your personal information may be used. We ask that you *read the following carefully*. Please check the lines to indicate your permission.

Telephone messages: At times, Psychiatric Services, PC, may need to contact you by phone. We also make appointment reminder calls. Please indicate if we may leave detailed messages and/or reminder calls on:

Home phone/cell phone:

Answering machine/voice mail

With a family member

OR

Leave callback number only

Work phone:

Answering machine/voice mail

OR

Leave callback number only

Written communication:

You may send mail (medical records, prescriptions, and or any other health information) to:

My home address

My work address

You may communicate with me by fax at this number: _____

Please check the following for which you give permission:

If my spouse calls Psychiatric Services, PC, requesting information in regard to my appointments or billing.

If a family member calls Psychiatric Services, PC, requesting information in regard to appointments or billing.

My Power of Attorney may need to be present at time of examination, may need to telephone or write Psychiatric Services, PC, for information regarding my health, appointments or billing.

If I have someone accompany me into the doctor's or therapist's office, I give permission for the doctor or therapist to discuss my case, test results, or any other health information in the person's presence.

I give permission to Psychiatric Services, PC, to allow someone other than myself to pick up my medication.

Signature _____ Date _____

Please print name _____

Unless otherwise noted, this release will remain in effect until the patient's treatment is completed.

Submit