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