MERIDIAN
PSYCHIATRIC
PARTNERS LLC

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize ________________________(clinician) to

☐ release my health information to the below facility/clinician:

☐ receive my health information from the below facility/clinician:

Outside facility/clinician: Phone of facility/clinician:

____

Address: Fax:

____ ________________________

____

☐ I understand that this information may be transmitted via written word, facsimile, or over the phone.

☐ I understand authorization for this release of information can be revoked at any time. To revoke this authorization, I understand that I must provide a statement in writing with my request.

☐ I understand that if I do not revoke this consent at any time, the consent will expire one year from the date of signing below.

☐ I understand that after completing this form, I do not have to sign additional consents for the release of my information.

Comments regarding the release of information (*i.e. specific information you do not wish to be released)*:

____
____
____
____

Patient Name (Print): Patient Signature: Date:

______________________________ ________________________________ ___________

Date of Birth: Clinician(s) at Meridian Psychiatric Partners:

______________________________ ____