MERIDIAN
PSYCHIATRIC PARTNERS

RELEASE AUTHORIZATION FORM

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 NUMBER

ADDRESS | FAX NUMBER

CITY | STATE | ZIP

☐ 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):

SIGNATURE

PATIENT NAME | DATE OF BIRTH

PATIENT/GUARDIAN SIGNATURE | DATE

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