



Samadhi Psychiatric

"It's the Journey that Matters"

Erik Morris PMHNP LLC

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AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Client's Name: _____ Birth Date: _____

I authorize **Erik Morris, PMHNP LLC** to:

[release] [request] [share] (circle all that apply) confidential medical record information:

[to] [from] [with] (circle all that apply):

Authorized Agency or Individual Name: _____ Phone/Fax: _____

Information shall consist of: Duplicate records/ verbal consultation concerning treatment and/or education.

- Specifically:
- | | | |
|---|---|---|
| <input type="checkbox"/> All Clinical Records | <input type="checkbox"/> Psychological Evaluation | <input type="checkbox"/> Educational Evaluation |
| <input type="checkbox"/> Medical History | <input type="checkbox"/> Psychological History | <input type="checkbox"/> Discharge Summary |
| <input type="checkbox"/> PCP Contract Form | <input type="checkbox"/> Master Treatment Plan | <input type="checkbox"/> Psychiatric Evaluation |
| <input type="checkbox"/> Mental Health Info | <input type="checkbox"/> Drug/Alcohol tests & results | <input type="checkbox"/> Drug/Alcohol diagnosis, treatment, referral info |
| <input type="checkbox"/> Other: _____ | | |

The information is needed for the purpose of adopting a more comprehensive and integrated approach to my health care and maintaining continuity and coordination of care unless otherwise permitted or required by law.

This authorization may be revoked at any time by the client. Revoking of this authorization shall not cancel any prior action that has already transpired.

A photocopy, facsimile or duplicate copy of this authorization shall be as valid as the original.

The person signing this consent has a right to receive a copy.

____ My Initials indicate that I have received a copy of this authorization to release medical records.

I have read and understand the nature of this release. I understand that I may revoke it at any time. I release the director, therapists, employees and the above-named organizations from any liability that may arise from this action whether or not foreseen at present. I understand that certain medical records (including any alcohol and drug abuse information) may be protected by Federal Regulations. (***Drug Abuse Office and Treatment Act of 1972 21 U.S.C. 1175; Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (42 U.S.C. 4582)*).

Signature of Client

Date

Signature of Legal Representative (If client is a minor or incapacitated)

Relationship to Client

Date

Witness

Date

OR: I do not give my mental health provider permission to contact my primary care physician, therapist or other type of provider.

Signature of Client

Date

*PRIVACY ACT STATEMENT

1. The authority for soliciting the information comes from 10 USC 3012
2. The purpose for soliciting the information is to provide the therapist/counselor data to assist in counseling you are seeking.
3. The information will be maintained under strict professional guidelines at the Erik Morris, PMHNP LLC and until, by law, your records are released to be destroyed.
4. Providing the information is voluntary. There will be no adverse effect on you for not furnishing the information other than that certain data might not otherwise be available to the counselor/therapist to enable him/her to provide you the most effective therapy.