Bright Minds psychiatry

www.brightmindspsychiatry.com
575 Washington St, Unit 1B, Canton, MA 02021
Phone: 508-375-8980
Fax 508-734-5005

## REQUEST/RELEASE OF CONFIDENTIAL INFORMATION

**Client's Name:** _____ **D.O.B:** ____ / ____ / ____

I hereby authorize: (Name and address of outside provider)

_____

_____

To ☐ send / ☐ receive the following information from the record of the above named client:

☐ Psychiatric evaluation
☐ Progress Notes; Psychotherapy Notes
☐ Medical Exam/Lab Results
☐ Psychological Testing Results
☐ Case History
☐ Hospital Admission and Discharge Summaries
☐ Other: _____
☐ All health information, excluding: _____

*This information is needed for the purpose of coordination of care.*

I understand that my record may contain information about infectious diseases including HIV/AIDS status, alcohol or drug abuse, STDs, information relative to the diagnosis and treatment of my mental or emotional conditions. I consent to this information being disclosed. I understand that the provider abides by Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), Public Law 104-191which protects the confidentiality of the record and that information in my record cannot be disclosed without consent unless otherwise provided for in the regulation.

I understand that this directive is subject to revocation at any time upon written request. Otherwise this consent will expire upon termination of care or from date: _____

I herewith release and hold harmless Bright Minds Psychiatry, PLLC and any contractors, agents, employees, directors or volunteers from any liability for the release of information provided in accordance with this directive.

If information is requested, please send to:
Bright Minds Psychiatry - Phone: 508-375-8980 - Fax 508-734-5005 - 575 Washington St, Unit 1B, Canton, MA 02021.
Signed under the pains and penalties of perjury:

**Client's Name / Guardians Signature:** _____ **Date:** _____

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*** REVOCATION** OF REQUEST FOR INFORMATION - To be signed when revoking this release.*
**Client's Name / Guardians Signature:** _____ **Date:** _____