HORIZON®
PSYCHIATRY, LLC

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MEDICAL RECORDS RELEASE FORM

PATIENT INFORMATION (Please Print)

LAST NAME: FIRST NAME: MIDDLE INITIAL: DATE OF BIRTH:

MR. MRS. MS.

This form when completed and signed by you, authorizes me to release protected health information from your clinical record to the person(s) you designate and vice versa.

I authorize my clinician listed under "PROVIDER INFORMATION" and/or his or her administrative staff to release and or receive records pretaining to and for the duration specified within the "SCOPE" listed below for the reasons stated under "PURPOSE":

PROVIDER INFORMATION HORIZON PSYCHIATRY OTHER (SPECIFY BELOW)

NAME OF PROVIDER: AUTHORIZATION: SEND RECEIVE

STREET ADDRESS: CITY: STATE: ZIP CODE:

BUSINESS PHONE: FAX NUMBER:

SCOPE ALL OTHER (Specify Below)

RECORDS PERTAING TO: UNTIL (Up to a Year)

PURPOSE AT MY REQUEST OTHER (Specify Below)

FOR THE PURPOSES OF:

I understand that my clinician cannot re-disclose information he/she received from another health care provider if that health care provider requested that the information not be re-disclosed.

I understand that my clinician generally may not condition psychiatric services upon my signing an authorization unless the psychiatric services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

SIGNATURE OF PATIENT/GUARANTOR DATE

HORIZON REPRESENTATIVE SIGNATURE-WITNESS DATE

If the authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided.