RecordsReleaseForm

Patient Name: ____

Send Records
To (Provider): ____

Office Phone: ____________________ Office Fax: ____________________

Office E-mail: ____

I voluntarily consent to authorize ________________________________(Doctors Office) to share/disclose my health information during the term of this authorization; that I have identified below.

I authorize my health care information be release to the recipient above. I am authorizing the release of my health information for the following purpose (check the applicable box) …

- ☐ NEW PROVIDER
- ☐ SHARE WITH PCP or other PROVIDER
- ☐ SUBMIT FOR FMLA
- ☐ AUTHORIZATION PURPOSES

I authorize the release of the following health information (check the applicable box) …

- ☐ ALL OF MY HEALTH INFORMATION THAT THE PROVIDER HAS IN THEIR POSESSION; INCLUDING INFORMATION RELATING TO ANY MEDICAL HISTORY, MENTAL OR PHYSICAL CONDITION, AND ANY TREATMENT RECEIVED BY ME
- ☐ Only Records from this date range: ____

This Authorization will remain in effect until the request if fulfilled. I understand that signing this form is voluntary and that if I do not sign it will not affect the quality and continuation of my treatment at CPS. If I change my mind, I understand that I can revoke this authorization by providing written notice to CPS, effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this authorization before it received my written notice of revocation.

_______________________________________ _____________________________
Signature Date

_______________________________________ ___________________________________
Name of Guardian/Representative Legal Relationship

_______________________________________ __________________________
Signature of Guardian/Representative Date

4900 Perry Highway
Building One Annex
Pittsburgh, PA
15229

Collaborative Psychiatric Services.
Tele: 412-307-5600
Fax: 412-301-0441