Capital Area Psychiatric Associates, P.L.L.C.
Child, Adolescent, and Adult Psychiatry

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AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Patient Name_____ Date of Birth_____

Address _____Telephone Number_____

I hereby authorize Capital Area Psychiatric Associates PLLC

to release my medical records to: _____

for the following reasons: _____

The health information includes: _____

Treatment dates include: _____

This authorization will expire one year from the date signed below unless specific expiration event or condition is named here:_____

The authorization covers only treatment for the dates specified above. I understand that I have the right to refuse to sign this Authorization for Release of Confidential Information form. I understand that authorizing the disclosure of this health information is voluntary.

I, the undersigned, have read the above and authorize the disclosing facility or person above to disclose such information as herein described. I understand that this authorization may be withdrawn by me at any time except to the extent that action has been taken in reliance upon it. I acknowledge that the material authorized for release may contain alcohol abuse, drug abuse, psychiatric, HIV testing, HIV results, AIDS, physical abuse, or sexual abuse information. I understand that the disclosure of health information to a party other than the one designated above is forbidden except as allowed by federal and state law for treatment, payment, and health care operations. I understand that health information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient unless the health information is protected under federal confidentiality rules. This facility or person is released and discharged of any liability and the undersigned will hold the facility harmless for the complying with this "Authorization for Release of Confidential Information" form.

_____ _____

Signature of Patient Date

_____ _____ _____

Signature of Parent, Guardian/Authorized Representative Date Relationship to Patient