Pebbles Psychiatry LLC
515 Court Street
Lower Level
Reno, NV 89501
PH: (775) 418-5990
FAX: (775) 418-5991

Authorization to Release Health Care Information

Patient Name: _____ Date of Birth: _____

Social Security #: _____

I request and authorize:

Pebbles Psychiatry LLC to □ **release**/ □ **receive** health care information of the patient named above to OR from the following agency/person:

Name: _____

Address: _____

City/State: _____ Zip Code: _____ Phone: _____

Date(s) of Service: From ___/___/___ To ___/___/___ or ___***ALL***

Information to be Disclosed: (Patient MUST INITIAL each item to be disclosed)

___ Psychiatric Evaluation ___ Psychiatric Progress Notes ___ Therapy Notes **

___ Intake Paperwork **

I understand that a revocation is not effective to the extent that Pebbles Psychiatry LLC has relied on the use of disclosure of the protected health information. I understand that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and may no longer be protected by the federal or state law.

Pebbles Psychiatry LLC will not condition my treatment, payment, enrollment into treatment, or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure. I understand that I have the right to inspect or copy the protected health information to be used of disclosed as permitted under federal law, or state law to the extent the state law provides greater access rights.

******Person requesting a release of information understands that drug, alcohol, and other substance use information will be included in the records as this is discussed at each visit.***

I authorize the records to be sent via:

_____ US Mail ____ Email _____Pick up at the office (scheduled)

Person signing understands that the CONFIDENTIALITY of records CANNOT be GUARANTEED if not picked up in person at the office at a scheduled time.

Record Requests can take UP TO 30 days to process

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____