Authorization to Release Health Care Information

1. PATIENT INFORMATION

Patient name _____ **Date of birth** _____

2. RECIPIENT OF THE INFORMATION

I authorize Pebbles Psychiatry LLC to release the records selected below to:

Name / organization _____

Address _____

City _____ **State** _____ **ZIP** _____ **Fax** _____

3. INFORMATION TO BE DISCLOSED

The patient or legal guardian must initial each item authorized for release.

Initials		Initials	
_____	Psychiatric evaluation	_____	Psychiatric progress notes

4. IMPORTANT INFORMATION

I understand that I may revoke this authorization in writing, except to the extent that Pebbles Psychiatry LLC has already acted in reliance on it. Information disclosed under this authorization may be re-disclosed by the recipient and may no longer be protected by federal or state privacy law.

Pebbles Psychiatry LLC will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. I understand that I may request a copy of this authorization and, as permitted by law, the protected health information disclosed under it.

Substance-use information may be included when it is documented in the selected records.
Email transmission carries privacy risks, and confidentiality cannot be guaranteed.

EMAIL THE COMPLETED FORM TO: christine@pebbles-psych.com
Please allow up to 30 days for processing.

5. SIGNATURE

Patient or legal guardian signature _____ **Date** _____

If signed by a legal guardian, print nam _____