



ARBOR PSYCHIATRIC AND WELLNESS CENTER

RELEASE OF INFORMATION

Patient Name (Last, First, MI)		DOB:
Patient Address	Phone Number	

I, or my legal representative, request that Lindsey Teten, APRN (provider) and/or Mindz, Inc. (business) disclose and/or exchange health information regarding my care and treatment with the individual or organization below:

Name: _____

Address: _____

Phone Number: _____ Fax: _____

- | | |
|---|--|
| <p>1. Specific type of information to be released: (initial appropriate areas)</p> <p><input type="checkbox"/> All records</p> <p><input type="checkbox"/> Attendance records</p> <p><input type="checkbox"/> Phone contact</p> <p><input type="checkbox"/> Psychiatric Assessment & Update</p> <p><input type="checkbox"/> Treatment Plan & Update</p> <p><input type="checkbox"/> Psychosocial Assessment & Update</p> <p><input type="checkbox"/> Medication Administration Record</p> <p><input type="checkbox"/> Prescribers Orders</p> <p><input type="checkbox"/> Discharge Summary</p> <p><input type="checkbox"/> Other, please specify: _____</p> | <p>2. I am requesting the release of this information for the following purposes: (initial appropriate areas)</p> <p><input type="checkbox"/> Information at the request of the individual</p> <p><input type="checkbox"/> Coordination of services</p> <p><input type="checkbox"/> Care/treatment</p> <p><input type="checkbox"/> Treatment planning</p> <p><input type="checkbox"/> Assessment/evaluation</p> <p><input type="checkbox"/> To follow up regarding a referral</p> <p><input type="checkbox"/> Other, please specify: _____</p> |
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- I understand that this authorization will not expire unless requested by patient/guardian.
- I understand that I may revoke this authorization at any time by notifying Arbor Psychiatric and Wellness Center at the address indicated below, verbally or in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations.
- I understand that the following information may be disclosed upon signing this release: information related to substance abuse, mental health diagnoses and treatment, HIV related information.
- I understand that my refusal to sign this Authorization will not jeopardize my right to obtain present or future treatment for psychiatric disabilities except where disclosure of the information is necessary for the treatment.
- I understand that I can request a copy of this form after I sign it.

Signature of Patient or Legal Representative: _____ Date: _____

Printed Name of Legal Representative: _____ Relationship: _____

Witness: _____ Date: _____