Healthstead PSYCHIATRY
...optimizing your mental health

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PA 19406.

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Healthstead Psychiatry Release of Information Form

Name Of Provider

Practice Address

Phone Fax Email

Release of Information

I hereby authorize

To: Release information to Obtain information from Exchange information with

Name

Address

Phone Number

The information requested or authorized for release or exchange pertains to

- [ ] Mental Health
- [ ] Mental Health Counseling / Psychotherapy
- [ ] Education
- [ ] HIV/AIDS
- [ ] Sexually transmitted diseases
- [ ] Drug or alcohol abuse

This authorization is valid until _____. I may cancel this authorization by signing, dating, and writing "**CANCEL**" on this original form or by sending a written, signed and dated request to the provider above indicating my desire to cancel. I understand that once my information has been released, the recipient might re-disclose it, my provider has no control over it and privacy laws may no longer protect it. The purpose of this authorization is to improve the quality of my mental health evaluation or treatment.

Patient's Name _____ Date of Birth _____

Parent's Signature _____ Date _____

Guardian's Signature _____ Date _____
(If patient is a minor)