NORTH SIDE
PSYCHIATRY

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize_____(clinician) to:

☐ Release my health information to the below facility/clinician.

☐ Receive my health information from the below facility/clinician.

OUTSIDE FACILITY & CLINICIAN PHONE NUMBER

ADDRESS FAX NUMBER

CITY STATE & ZIP

- I understand that this information may be transmitted via written word, facsimile, or over the phone.
- I understand authorization for this release of information can be revoked at any time. To revoke this authorization, I understand that I must provide a statement in writing with my request.
- I understand that if I do not revoke this consent at any time, the consent will expire one year from the date of signing below.
- I understand that after completing this form, I do not have to sign additional consents for the release of my information.
- I understand that the information discussed includes behavioral health and substance use treatment

Comments regarding the release of information (i.e. specific information you do not wish to be released):

SIGNATURE

PATIENT NAME DATE OF BIRTH

PATIENT/GUARDIAN SIGNATURE DATE