# Authorization to Release Information

**Cleveland Psychiatry Associates**
6909 E Royalton Rd #201
Brecksville OH 44141
Phone: 440-630-9426

Patient First Name: _____ Last Name: _____ DOB: _____

Address: _____ City:_____ State: _____ Zip: _____

Phone: _____ Email: _____

☐ I authorize Cleveland Psychiatry to **RELEASE MY RECORDS** to the following organization/individual.

*Method of Delivery:* ☐ Fax ☐ Mail ☐ E-mail ☐ Will Pick-Up

☐ I am **REQUESTING EXTERNAL RECORDS** from the following organization/ individual be sent to Cleveland Psychiatry.

*Please return records via:* Fax: 440-630-9129 or
Email: service@clvpsych.com

☐ to **VERBALLY COMMUNICATE** with the following organization/individual

Relation: _____

Name or Facility: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____ Fax: _____

Email: _____

## Purpose of Disclosure:

☐ Continuity of Care ☐ Disability Determination ☐ Legal ☐ At Patient's Request

☐ School / Employment ☐ Other: _____

## Information to be Disclosed:

☐ Specific dates/years of Treatment: _____

☐ All Records ☐ Progress Notes ☐ Lab Results

☐ Diagnosis ☐ Medication List ☐ EKG

☐ Appointment Information ☐ Letters/Paperwork ☐ Discharge Summary

☐ Other: _____

By signing this I understand that:

◇ I understand that this authorization may include information concerning testing, diagnosis or treatment of HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), PSYCHIATRIC and/or DRUG/ALCOHOL TREATMENT and/or ASSAULT RECORDS that may be in my medical record.

◇ I understand that if the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed by such person or entity and will likely no longer be protected by the privacy regulations. Therefore, Cleveland Psychiatry Associates is released from all liability resulting from re-disclosure.

◇ I may revoke this authorization at any time, but understand that revoking this authorization does not apply to information that has already been disclosed under this authorization.

Patient's Signature _____ Date _____

Parent or Guardian Signature (if Patient a Minor) _____