Carpenter House, Inc.
Shari Adams, MA, LMHC
4400 Highway 20 East Suite 306
Niceville, FL 32578-5383
Phone: 850-897-7810 Fax: 850-897-0032
www.carpenterhouse.net

**RELEASE OF INFORMATION FORM**

Date:_____ Authorization good for one year unless otherwise specified here – Expires on:_____

**Client may terminate this consent at any time by sending a written request to the facility/person identified to release records. Receipt of a termination request will cancel future actions, but cannot reverse actions previously completed. Client has right to their signed copy of this notice.**

Patient:_____DOB:_____

Person completing form: _____Relationship to patient:_____

If you would like NO RECORDS RELEASED under any circumstances except as allowable by law please sign here _____and STOP DO NOT FILL OUT THIS FORM

**Coordination of treatment**: In order to provide you with the best possible care I request your permission to speak with your Primary Care Manager (PCM) and/or your Psychiatrist to inform them that I am providing treatment for you.

By initialing here I acknowledge that I am allowing correspondence with my PCM: _____

By initialing here I acknowledge that I am allowing correspondence with my Psychiatrist: _____

| | | |
|---|---|---|
| PCM: | Phone: | Fax: |
| Psychiatrist: | Phone: | Fax: |

Please choose ONE of the methods of delivery for records requested personally by initialing next to your choice:
I will pick up copies of my records: ☐ Fax my records:☐ Mail copies of my records: ☐ Provide records in electronic format: ☐

Shari Adams, MA, LMHC is hereby authorized to request your medical records *FROM* the following
RECEIVE FROM Provider:_____ Phone:_____ Fax:_____
Please send the following medical records **If an area is not marked please do not send that type of record:
Mental Health ☐ Health History ☐ Immunization Records☐ Substance or Alcohol Abuse ☐ Domestic violence/sexual assault ☐ HIV related ☐

I acknowledge release of my records for the purpose of:_____
Shari Adams, MA, LMHC is hereby authorized to send a copy of your medical records TO the following:
SEND TO Provider:_____Phone:_____ Fax:_____
Please send the following medical records **If an area is not marked please do not send that type of record:
Mental Health ☐ Psychological Evaluations ☐ Progress Notes ☐ Substance or Alcohol Abuse ☐
Domestic violence/sexual assault ☐ HIV related ☐ **Psychotherapy notes maintained by the provider ☐ * WILL REQUIRE SEPARATE AUTHORIZATION**

If you are a Tricare recipient and have received a referral from a military treatment facility or provider we are required to send a Consult Treatment Report to the referring provider. If you do not agree to this you may sign that you decline and we will notify Tricare. _____

As the person signing this form I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations. I acknowledge that these records will not be released without written authorization by the patient or legal guardian except for when there is a duty to warn or as allowed by federal guidelines. Provision of treatment cannot be conditioned on my signing of this authorization. Required by the Health Insurance Portability and Accountability Act ---- 45 CFR Parts 160 and 164. I have the right to inspect or copy the records to be used or disclosed.

**Patient or Guardian Signature:_____**

**Date:_____Witness:_____**