

Carpenter House, Inc.
Kathlyn C. White, MA, LMHC, LMFT, QS



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:

Kathlyn C. White, MA, LMHC, LMFT, QS 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: _____

Kathlyn C. White, MA, LMHC, LMFT, QS 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:** _____