CENTER FOR MOOD DISORDERS INC

1408 19TH STREET, SUITE C
VERO BEACH, FL. 32960
(772) 224-1294 MAIN
(772) 494-7693 FAX

WRITTEN CONSENT FOR RELEASE OF MEDICAL RECORDS

I, _____,with a date of birth,_____, give my permission for
(patient name) (patient's DOB)

the Center for Mood Disorders LLC to communicate my medical records/personal PHI as listed

below with_____at_____
(person/entity sharing/receiving Medical/PHI information) (person/entity address)

phone # _____fax # _____so that we can better understand my condition and help me.

Permission to exchange sensitive information
By putting my initials by each item below, I understand that I give permission for records to be disclosed in person, by mail or by fax that may contain information about:

_____my medical/mental health assessments and evaluations
_____my medical/mental health diagnosis
_____my current or past medications
_____my mental health treatment, attendance and progress
_____permission to speak to the person/entity listed via phone or face-to-face
_____other (listed on the next line)

_____

I understand that:

- I do not have to give my permission for the Center for Mood Disorders LLC to share any obtained records with other individuals or entities outside of their office.
- If I want to take away the permission for the above named person and/or entity to give these records, I need to talk to my psychotherapist or a staff person and sign a paper.
- This form is good for 12 months from the date I sign it.
- I understand by approving the release of information in the form of a facsimile (FAX), confidentiality cannot be assured. My initials indicate that I accept the risks that confidentiality may be breached when FAXING information. Client/Rep. Initials(_____)

Patient Signature_____Date_____

Witness Signature_____Date_____