Dr. Michael A. Hernandez

Of MHernandez MD, PLLC

Request/Authorization to Release Confidential Records and Information

I, _____, hereby authorize the following person or facility:

_____

Address: _____Phone: _____

to release information from records about _____, born on _____, and whose Social Security number is _____, for the following purpose(s):

☐ Further mental health evaluation, treatment, or care
☐ Rehabilitation program development or services
☐ Treatment planning ☐ Research ☐ Other: _____

These records concern the time between _____ and _____.

The information to be disclosed is marked by an x in the boxes below, and the items not to be released have a line drawn through them. ☐ Intake and discharge summaries ☐ Medical history and evaluation(s)☐ Mental health evaluations☐ Educational records ☐ Developmental &/or social history ☐ Progress notes & treatment or closing summary ☐ Other: _____

Please forward the records to the address/fax in the letterhead at the bottom of this form.

HIV-related information and drug and alcohol information contained in these records will be released under this consent unless indicated here: ☐ Do not release.

I understand the information disclosed by this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability & Accountability Act of 1996. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time within 90 days, except to the extent that action based on this consent has already been taken. This consent will expire automatically after 90 days from the date on which it is signed, or upon fulfillment of the purposes stated above.

_____	_____	_____
Signature of Patient or Guardian	Printed Name	Date

I witnessed that the patient understood the nature of this request/authorization and freely gave his or her consent, but was physically unable to provide a signature.

_____	_____	_____
Signature of Witness	Printed Name	Date

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