Mental Health Partners
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REQUEST FOR RELEASE OF MEDICAL RECORDS
& Coordination of Care

I ____, hereby authorize Mental Health Partners to:

__Release Information to __Obtain Information from _ Talk face to face with _ Have phone contact with

- Check if PCP (Primary Care Physician)

For the purpose of: _____Healthcare ______Legal _____Other

Name: ____ Phone: (____) ______________________

Address: ____

Information requested to be released: **Behavioral Health Record** (may include, any and all mental health, records including Diagnosis, Initial Evaluation, Progress Notes, Medications, other)

I understand if the recipient authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal and state privacy regulations. *I understand I have the right to revoke this authorization at any time.* I understand if I revoke this authorization, I must do so in writing and present my written revocation to the Medical Records Department.

I understand the revocation will not apply to information that has already been released in response to this authorization. I understand authorization for the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure health care treatment.

I further understand that my health care and the payment of my health care will not be affected if I do not sign this form. Mental Health Partners, its employees and attending physicians are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

Patient /Guardian Signature: ________________________________ Date: __________________________