Integrated Psychiatry

5444 Westheimer Rd, Suite 1535
Houston, TX 77056
Phone: (713) 510-0024
Fax: (713) 405-2117

Release of Information Form

I hereby authorize the use or disclosure of health information from the medical record of:
Patient name: _____ Date of birth: _____
Address: _____
Patient phone number: _____

Records requested from Integrated Psychiatry
5444 Westheimer Rd, Suite 1535, Houston, TX 77056 Phone: (713) 510-0024
Email: HoustonPsych@yahoo.com Fax: (713) 405-2117

I authorize Integrated Psychiatry to release confidential health information about me, by releasing a copy of my medical records, a summary or narrative of my protected health information, or verbally to the individual or organization listed.

This information may be disclosed from the following individual or organization:
Name: _____
Address: _____
Phone: _____ Fax: _____

Description of Information to be released:

- ☐ Progress Notes
- ☐ Radiology
- ☐ Information from family/friend
- ☐ Labs
- ☐ Counseling records
- ☐ Other: _____
  _____

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire in 1 year or on the following date, event, or condition: _____. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X_____ _____
Signature of Patient / Parent / Guardian or Authorized Representative Date
(Guardian or Authorized Representative must attach documentation of such status)

_____ _____
Printed name of Authorized Representative Relationship / Capacity to patient