Cantwell Family Psychiatry, PC
Post Office Box 392, Fairhope, AL 36533
DrJohnCantwell.com 251-517-5800 | Fax 251-517-5801

Release/Request Patient Medical Records

Patient Name _____Date of Birth _____
Address _____ City _____ State _____ Zip_____
Home Phone _____ Cell _____ Work _____
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I hereby authorize Cantwell Family Psychiatry, PC to release/request my Protected Health Information from the following (check one or both): X Disclose to and/or X Obtain from:

Name: Ms. Lisa Golden, Medical Records Director, Comprehensive MedPsych Systems
Address: 1090 S. Tamiami Trail City: Sarasota State: FL Zip: 34236
Phone: 941-363-0878, Ext. 2071 (Option 5) Fax: 716-242-3360

Protected Health Information to be disclosed and/or obtained:

_X__ All Mental Health Information/Notes
_X_ Intake and Discharge Evaluations
_X_ Psychiatry & Psychotherapy Notes
_X_ Psychological/Educational Testing Reports
___ Other: _____
_X_ All Medical Records
___ History & Physical Exam
___ Progress Notes
_X_ Labs, EKGs, Radiology, & Medical Reports
___ Other: _____

Purpose of Disclosure:
_X_ Continuing Care ___ Educational Coordination ___ Family/Friend Involvement ___ Legal Matter
___ Other: _____

By signing this Authorization Form, I understand that I am giving my authorization to Cantwell Family Psychiatry, PC, as medical record custodian, to release to and/or obtain my Protected Health Information including Medical, Psychiatric, Psychological, Alcohol Abuse, Drug Abuse, HIV/AIDS, and or Financial Information contained in my records to or from the abovementioned Physician, Health Care Provider/Organization, or Individual(s). I further understand that I may revoke this authorization at any time, except to the extent that any action has been taken in reliance on this authorization. I can revoke this authorization by submitting a written request to Cantwell Family Psychiatry, PC.

I certify this authorization is made voluntarily. I understand that the information to be released/obtained is protected under state and federal laws and cannot be disclosed again without my further written consent, unless provided for by state or federal law. I understand that the stated recipient, if not a health care provider or plan, may not be subject to privacy laws and that my protected health information may be further disclosed without privacy regulation protection. I understand that I am not required to sign this form to receive treatment from Cantwell Family Psychiatry, PC.

This authorization will expire in 1 year from the date of signing below, unless specified otherwise.
Date of expiration, if different _____

Signature of Patient/Patient's Representative _____ Date _____

Print Name of Patient/Patient's Representative _____

Relationship to Patient _____

Witness Signature _____ Date _____