Alabama Psychiatric Services

Authorization for the Release of Protected Health Information

This completed form authorizes and requests Alabama Psychiatric Services, P.C. ("APS") to **release** the following patient's information:

Office Location: _____

Patient's Name: _____ DOB: _____ SS#: _____

I, the undersigned, authorize and request APS to release the following **specific** patient information: (include dates of service, type of service, etc.)

1. _____
2. _____
3. _____
4. _____

I understand that this authorization will result in the release of clinical information regarding the patient's diagnosis, behavioral or mental health condition, substance abuse history, and psychiatric and/or counseling services. I understand that these records are strictly confidential and solely for the information of the person to whom addressed.

This information is to be released to: (**specific name and address**) _____

_____

_____

I also authorize APS to discuss the patient information with the above-named person and/or entity.

This information is to be released for the **specific** purpose(s) of: (if authorization requested by the patient, put "at the request of the individual")_____

_____

This authorization is valid for one year from the date listed below. You may revoke this authorization at any time by notifying APS in writing, but such revocation will have no effect on disclosures of information already made under this authorization prior to receipt of the revocation. This authorization is voluntary and you may refuse to sign the authorization and the patients' treatment or payment obligations will not be affected by this authorization unless (i) the treatment is related to research and the use and/or disclosure is related to such research, or (ii) the treatment is solely for the purpose of creating protected health information for disclosure to a third-party. Upon signature, you may receive a copy of this authorization. The information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by state or federal law. APS will not receive financial or in-kind compensation or remuneration in exchange for the use and/or disclosure of the patient's information unless an applicable legal exception applies. This authorization is continuing in nature and is to be given full force and effect to release any and all of the foregoing information learned or determined after the date hereof until the expiration date. I hold APS, its employees, directors, officers, agents and representatives harmless from any and all damages which might result to myself, the patient, our representatives, heirs, and/or assigns from the disclosure of this information. A copy or facsimile of this authorization shall be valid and effective, just as the original.

_____ **Date:** _____
Patient Signature

_____ _____ **Date:**_____
Parent/Patient Representative Signature (If Applicable) **Printed Name and Relationship to Patient (If Applicable)**

_____ **Date:** _____
Witness Signature

Due to the closure of all APS offices and the extremely high volume of requests for disclosures of protected health information, there may be some unavoidable delay in the processing of your request. All requests will be processed as soon as possible.