BRIGHT FUTURES PSYCHIATRY RELEASE OF INFORMATION REQUEST

Please fill out and submit this form to Bright Futures Psychiatry. If you have any questions please call us at (719) 289-3173.

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE, AND SIGN

I. I, _____, hereby voluntarily authorize the disclosure of information from my health record.
Last, First, MI

ADDRESS _____ CITY _____ STATE _____ ZIP _____

DATE OF BIRTH _____ MEDICAL RECORD NUMBER _____

II. The information is to be disclosed by:		**And is to be provided to:**	
NAME OF FACILITY		NAME OF PERSON/ORGANIZATION/FACILITY **Bright Futures Psychiatry**	
ADDRESS		ADDRESS **4729 Opus Dr**	
CITY/STATE/ZIP		CITY/STATE/ZIP **Colorado Springs, CO 80906**	
EMAIL	FAX	EMAIL **info@brightfuturespsychiatry.com**	FAX **(866) 718-1677**

III. The purpose or need for this disclosure is:

☐ Further Medical Care ☐ Attorney ☐ School ☐ Research ☐ Other *(Specify)* _____

☐ Personal Use ☐ Insurance ☐ Disability ☐ Health Information Exchange (Other _____)

IV. The information to be disclosed from my health record: *(check appropriate box(es))*

☐ Only information related to *(specify)* _____

☐ Only the period of events from _____ to _____

☐ Other *(specify)* _____

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

☐ Alcohol/Drug Abuse Treatment/Referral ☐ HIV/AIDS-related Treatment

☐ Sexually Transmitted Diseases ☑ Mental Health (*Other Psychotherapy Notes*)

☐ Psychotherapy Notes ONLY (by checking this box, I am waiving any psychotherapist-patient privilege

V. I understand that I may revoke this authorization in writing submitted at any time to Bright Futures Psychiatry, except to the extent that action has been taken in reliance on this authorization. **This authorization expires 12 months from the date originally submitted to Bright Futures Psychiatry unless new date specified**.

Expires on: _____
(Specify New Date)

I understand that Bright Futures Psychiatry will not condition treatment or eligibility for care on my providing this authorization except if such care is: (1) research related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to re-disclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164] , and the Privacy Act of 1974 [5 USC552a].

PATIENT OR PERSONAL REPRESENTATIVE *(State relationship to patient)*		DATE
Signature	Print Name	Relationship to Patient
SIGNATURE OF WITNESS		DATE
Signature	Print Name	

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. It is unlawful to knowingly and willfully request or obtain any records concerning an individual from Bright Futures Psychiatry under false pretense.

BRIGHT FUTURES PSYCHIATRY