

Consent for Release of Confidential Mental Health/Substance Abuse Records

Phone Number Fax Number For the purpose of: Continued Care Personal Litigation Insurance Claim (Circle one) Other:	Patient Name			Date of Birth			
Name or Facility Address City State Zip Code Phone Number Fax Number For the purpose of: Continued Care Personal Litigation Insurance Claim (Circle one) Other:	Authorize:	Jay D. 5915	Schmauch, DO S. Regal St, Suite 311				
Address Code Phone Number Fax Number For the purpose of: Continued Care Personal Litigation Insurance Claim (Circle one) Other:	Release to or	r Obtair	a from (circle one or bot	h):			
Phone Number Fax Number For the purpose of: Continued Care Personal Litigation Insurance Claim (Circle one) Other:	Name or Fac	ility					
For the purpose of: Continued Care Personal Litigation Insurance Claim (Circle one) Other:	Address Code			City	State	Zip	
Claim (Circle one) Other:	Phone Numb	er		Fax Number			
Entire recordAll records from date forward:Last chart noteAllow telephone contact _Lab recordsPsychological/drug testing _AssessmentReport/psychiatric evaluation _Other: RESTRICTIONS: This consent includes authorization to release alcohol, drug abuse, and mental health records obtained in or for the diagnosis, treatment, consultation or evaluation. I understand that I may revoke this consent at any time, except to extent the action has already been taken in reliance hereon and if not revoked sooner in writing. The consent is valid for the duration of treatment, unless otherwise revoked in writing. You are no required to sign this consent in order to receive treatment, unless this is for a Fitness for Duty Exam or for participating in a medical research study. Please note when you request records be released to a third party, that party may NOT be subject to redisclosure or privacy regulations.	Claim	ose of:			J	Insurance	
This consent includes authorization to release alcohol, drug abuse, and mental health records obtained in or for the diagnosis, treatment, consultation or evaluation. I understand that I may revoke this consent at any time, except to extent the action has already been taken in reliance hereon and if not revoked sooner in writing. The consent is valid for the duration of treatment, unless otherwise revoked in writing. You are no required to sign this consent in order to receive treatment, unless this is for a Fitness for Duty Exam or for participating in a medical research study. Please note when you request records be released to a third party, that party may NOT be subject to redisclosure or privacy regulations.	Entire recordLast chart noteLab recordsAssessment			Allow telephone contact Psychological/drug testing			
for the diagnosis, treatment, consultation or evaluation. I understand that I may revoke this consent at any time, except to extent the action has already been taken in reliance hereon and if not revoked sooner in writing. The consent is valid for the duration of treatment, unless otherwise revoked in writing. You are no required to sign this consent in order to receive treatment, unless this is for a Fitness for Duty Exam or for participating in a medical research study. Please note when you request records be released to a third party, that party may NOT be subject to redisclosure or privacy regulations.	RESTRICTIO	NS:					
Patient Signature Date	for the diagno time, except to writing. The or required to sig participating i Please note when	sis, treat extent to consent is gn this co n a medi hen you	ment, consultation or evaluhe action has already been so valid for the duration of tonsent in order to receive to cal research study.	uation. I understand that n taken in reliance hereon reatment, unless otherwi reatment, unless this is fo	I may revoke thi and if not revoke se revoked in wr or a Fitness for Du	s consent at any ed sooner in iting. You are not uty Exam or for	
	Patient Signat	ure			Date		

[Type here] [Type here] Revised 1-2-17