Genesis Psychiatric services

Authorization for Release of Information

Date: ______________

Patient Name: _________________________DOB: _________________

I hereby authorize the release of my protected health information

From/To: Genesis Psychiatric Services

237-A Castlewood Drive

Murfreesboro, TN 37129

Fax (615) 849-3730

From/To: ____

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I understand that this information will be used in the development of a diagnosis and treatment plan and/or to coordinate medical, psychological, and social rehabilitative services.

I understand that this information will not be disclosed to any other agency or individual without my written authorization, except as allowed by law. I also understand that any agency or individual who receives my protected health information is prohibited from re-disclosing the information. Furthermore, I understand that my treatment can not be conditioned upon my signing this form.

I understand that I have the right to a copy of this authorization after I sign it.

This authorization may be revoked at any time by my written statement. This authorization for release of information is given freely, voluntarily, and without coercion.

____________________________ ________________________________

Signature of Client Date Signature of Parent/ Guardian: Date

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Signature of Witness Date