The Healthy Mind Psychiatric Services, PC

900 Straits Turnpike Suite D

Middlebury, CT 06762

Authorization for Release of Medical Records

Patient Information:	Request Release From:
________________________________	__________________________
________________________________	______________________________
________________________________	______________________________
Date of Birth: ____________________	______________________________
Social Security #: ___________________	______________________________

I hereby authorize you to release to _________________________________ a copy of my medical records to be used for continuing medical care. I reserve the right to revoke this authorization in writing at any time. Further, I understand that this Protected Health Information (PHI) may be re-disclosed by the recipient and thus, no longer protected under privacy rules.

____________________________	______________________
Patient or Guarantor Signature	Date

Please include the following items:

_________ Admission notes	_________ Progress notes
_________ Discharge summary	_________ Pathology reports
_________ Operative notes	_________ Consultation notes
_________ EKGs	_________ Laboratory tests
_________ X-ray reports	_________ Stress test

_________ Other: ____

Remarks: ____

This authorization will expire on: ____