Tidal Mental Health
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AUTHORIZATION FOR RELEASE/EXCHANGE OF CONFIDENTIAL RECORDS/INFORMATION

I, _____, date of birth _____,
(Patient Name) *(mm/dd/yyyy)*

hereby authorize the release or exchange of the following information:

____ Psychiatric/medical/substance abuse eval ____ Psychiatric/medical/substance abuse d/c summary
____ Progress notes ____ Psychological testing ____ Psychotherapy notes
____ Educational testing ____ Lab studies ____ Medical tests/studies
____ Other: _____

for the purposes of: ____ Continuity of care ____ To inform treatment
____ Other: _____

TO: Name/Facility: _____
Address: _____
Phone number: _____ Fax number: _____

FROM: Name/Facility: _____
Address: _____
Phone number: _____ Fax number: _____

I have had it explained to me and fully understand that this authorization for release or exchange of confidential records and/or information, including the entire nature of said records, their content, and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may rescind this authorization at any time within 90 days, except to the extent that action based on this authorization has already been taken.

Name (print): _____ Date of Birth: _____

Signature: _____ Date: _____

When patient is a minor, or is unable to give consent, the signature of a parent, guardian, or other representative is required.

Name of Representative (print): _____ Relationship to Patient: _____

Signature: _____ Date: _____