



RELEASE OF INFORMATION

Patient Name: _____
Last _____ First _____ MI _____

MRN: _____

Date Of Birth: _____ / _____ / _____
Month Day Year

Phone: _____

I authorize Tapestry 360 Health to release medical records (which may be copied, orally communicated, or faxed) from *my* record as stated below

Information to be released FROM:	Information to be released TO:
	Organization/Person Name
	Street Address
	City, State, Zip
Phone: 872-260-3852 Fax : 773-437-6812	Phone: _____ Fax: _____

Sensitive Information (Initial below if you do NOT want the following info to be disclosed):

HIV/AIDS Mental Health Alcohol/Substance Use Genetic Testing

For the following dates of treatment: -- to ____/____/____ (If blank, we will release records from the past 12 months)

Type of information (entire record will be released unless specified) _____

Purpose of Disclosure: Transfer of care to another provider Referral/Consultation Insurance claim
 Personal use Disability determination Other:

This authorization is valid until ____/____ (Date not to exceed 1 year)

I acknowledge that I have fully reviewed and understand the contents of this form. I acknowledge that a photocopy or fax of this form is valid. I understand that

I have the right to inspect and receive a copy of the information to be disclosed.

I understand that I may refuse to consent to the release of the above information and that I may revoke this authorization at any time except to the extent action has already been taken.

I understand that my consent is voluntary; however, my refusal may hamper further evaluation or treatment.

I understand that if the persons or organizations I authorized above to receive and/or use the PHI described above are not subject to federal health information privacy laws, they may further disclose the PHI and it may no longer be protected by federal health information privacy laws.

I understand that if the patient is 12-17 years old, the patient must sign this consent in order to disclose certain protected information, pursuant to the Consent by Minors to Medical Procedures Act and the Mental Health and Developmental Disabilities Confidentiality Act

Signature of Patient or Legally Authorized Representative

Date

Signature of Minor if Patient is 12-17 years old

Date

If Not Patient, then Name and relationship to Patient (for example: Parent)

Date

Signature of Tapestry 360 Health Staff Member

Date