Stepping Stones Psychiatric Services, PLLC

Authorization for Release of Information

Patient Name:_____ Date of Birth: _____

Address: _____ ___ City:_____ __ State: _____ Zip:_____

I hereby authorize the release of protected health information. I understand that the specific information to be disclosed may include information regarding alcohol and drug diagnosis and/or information regarding testing and treatment for Acquired Immune Deficiency Syndrome (AIDS).

Discharge Summaries	☐ Yes	☐ No	Current Medications	☐ Yes	☐ No
Psychological Evaluations	☐ Yes	☐ No	Alcohol/Drug Treatment	☐ Yes	☐ No
HIV/AIDS Testing/Treatments	☐ Yes	☐ No	Admission History, Reports	☐ Yes	☐ No
Treatment Plans	☐ Yes	☐ No	Entire Medical Record	☐ Yes	☐ No
Other (specify) _____				☐ Yes	☐ No

FROM and TO: Stepping Stones Psychiatric Services, PLLC
5214 Maryland Way Suite 107 Brentwood, TN 37027
Phone: (615) 628-7176 Fax: (615) 454-2901

TO and FROM: _____

(Name)

_____

(Address)

Phone: _____ **Fax:** _____

Purpose of Disclosure: To communicate medical, psychiatric and case management services to ensure quality and continuity of care in accordance with HIPPA standards.

This consent is subject to revocation at any time upon written notice, except to the extent that Stepping Stones Psychiatric Services, PLLC has already taken action in reliance on it. The consent will expire in six (6) months from date signed.

This consent is given freely, voluntarily and without coercion.

_____ _____

Signature of Patient/Legal Guardian Date

_____ _____

Signature of Witness Date