Healthy Foundations Group
A Team Approach to Superior Care.

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Mental Health and Medical Records Release Request

INSTRUCTIONS: Complete this form in its **entirety** and forward the original to the address above:

Please complete a separate form for each requestor

IDENTIFYING INFORMATION:

Patient Name	Daytime Telephone	Date of Birth

REQUESTOR INFORMATION: Information is to be released to the following individual or party:

Name			Telephone
Address			Fax Number
City	State	Zip Code	Country

Date Range of Information to be Released: from _____ **(month/year)** **to** _____ **(month/year)**

Please check specific information to be released:

- ☐ Discharge Summary
- ☐ History & Physical
- ☐ Outpatient Medication Management Notes
- ☐ Outpatient Psychotherapy Notes
- ☐ Consultation Reports
- ☐ Lab Results
- ☐ Radiology Reports
- ☐ Other (Please Specify):_____

The purpose or need for disclosure: _____

AUTHORIZATION: Permission is hereby granted to the Healthy Foundations Group, LLC to release mental health and medical information to the individual/organization as identified above. This authorization may be revoked at any time upon your request.

Patient Signature	Print Name	Date
Parent/Authorized Signature (if applicable)	Print Name/Relationship	Date