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132 Demanade Boulevard
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Aspire
Behavioral Health Center

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient's Name: ______________________________ Date of Birth: ____________

I request and authorize Aspire Behavioral Health Center and/or its related treatment providers Dr. Joslyn McCoy, Dr. Kimberly David, Dr. Eleanor Heaton, Michelle Thomas to release or request healthcare information of the patient named above to:

Name: ____

Address: ____

Phone Number and Fax: ____

This request and authorization applies to:

○ All healthcare information related to EVALUATION, DIAGNOSIS, and TREATMENT PLAN unless otherwise specified here: ____

____

I understand and acknowledge that this may include alcohol/drug abuse, mental health, or HIV/AIDS information.

Purpose of disclosure: continuity of care

Information requested: evaluation, diagnosis, and treatment plan

I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. This authorization will expire 1 year after the date signed. The requestor should not further disclose my medical record to another party without further written consent. I will not hold Aspire Behavioral Health Center and/or its related treatment providers Dr. Joslyn McCoy, Dr. Kimberly David, Dr. Eleanor Heaton, Michelle Thomas liable for any injury, whether mental or physical, resulting from any misunderstanding of information in the released report as a result of my not asking for clarification of the information therein.

Print Name: _________________________________ Patient Name: ____________________________

Signature of patient or parent/guardian: ______________________________Date signed: ________

Witness: ____ Date signed: ________