NORTHPOINT PSYCHIATRIC CONSULTANTS, LLC

363 Main Street, Suites 412 & 413
Middletown, CT 06457
P: (860) 799-1626
F: (949) 561-4993
support@northpointpsychiatry.com

Authorization to Release / Obtain Medical Records

Client Name: ______________________________ Date of Birth: ______________

Address: ____

City: ______________________ State: ________ Zip: ______________

Preferred Phone: ______________________ ☐ HOME ☐ CELL ☐ WORK

I hereby authorize NorthPoint Psychiatric Consultants, LLC to:

☐ **Release** Protected Health Information from my medical records to: ☐ **Obtain** Protected Health Information from my medical records from:

Name: ______________________________ Fax: ______________________

Address: ____

City: ______________________ State: ________ Zip: ____________

INFORMATION TO BE RELEASED OR ACCESSED IN EITHER VERBAL OR WRITTEN FORM

Dates of Service: ______________ ______________

☐ All medical records *including if applicable*, information relating to the diagnosis or treatment of mental illness, drug and/or alcohol abuse and confidential HIV related information

☐ Medication records only ☐ Labs and imaging studies only ☐ The following specific info only:

Purpose of Disclosure:

☐ Coordination of Care ☐ School / College ☐ Family Member Access to Treatment

☐ Consult/Second opinion ☐ FMLA / Disability ☐ Insurance application (e.g., long-term care)

☐ Transfer of Care ☐ Legal (Please specify): ______________ ☐ Other: ______________

1. I understand that this authorization will expire one year after I have signed this form, or as specified here: ______________________
2. I understand that I may revoke this authorization at any time by notifying NorthPoint Psychiatric Consultants, LLC in writing, and my revocation will be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by privacy regulations.
4. I understand that I am not required to sign this form in order to receive treatment.
5. I understand that there may be a fee for a copy of my medical record.
6. I understand that information to be released or obtained may include mental health information in accordance with CGS 52-146(d), substance abuse treatment information in accordance with 42 CFR 2.1-2.67, and/or HIV/AIDS-related information in accordance with CGS 19a-585(a), except as indicated below.

   ☐ No Substance Abuse treatment should be disclosed ☐ No HIV/AIDS information should be disclosed

____
Print Name of Client

______________________________ ______________
Signature of Client or Personal Representative Date

______________________________ ______________
Print Name and Relationship of Personal Representative Date

Please send to:

NorthPoint Psychiatric Consultants, LLC
363 Main Street
Suites 412 & 413
Middletown, CT 06457
Fax: (949) 561-4993
Email: support@northpointpsychiatry.com