NewLight Psychiatric Services

5302 S Florida AVE, Suite 203 Lakeland FL-33813 **Telephone: 863-602-7001**
Fax: 863-583-8585

Patient Authorization for Release of Information

Patient Name: _____ DOB: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Patient authorizes the following facility/provider to disclose information specifically described below:

Facility/Provider: NewLight Psychiatric Services

Information to be used/disclosed is specifically described below:

Office Notes: Date (s) of Service:_____

Diagnostics: Type of Report (s):_____

Labs: Date(s) of Service: _____

Other (Specify): _____

Purpose of Disclosure:

Legal Insurance Personal Use Continuity of Care Other (Specify): _____

This information may be disclosed to and used by the following individual or organization:

RELEASE TO PATIENT

RELEASE TO /RECEIVE FROM /EXCHANGE WITH: (please circle one)

Facility / Physician: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

THIS AUTHORIZATION SHALL EXPIRE ONE (1) YEAR FROM THE DATE OF SIGNATURE UNLESS OTHERWISE NOTED HERE: _____

IMPORTANT: By signing below, patient understands this Authorization of Release of Medical Records ("Authorization") shall include medical records dated prior to, inclusive of, and up to one year following the date of the Authorization. Patient understand this Authorization shall only include medical records originated through NewLight Psychiatric Services and/or its affiliates unless otherwise specifically requested. Patient further understands that this Authorization is voluntary and may refuse to sign it. If patient refuses to sign, patient's refusal will not affect his/her ability to obtain treatment. Patient understands that this Authorization may be revoked at any time by notifying NewLight Psychiatric Services. However, revocation shall not be valid to the extent NewLight Psychiatric Services has taken action in reliance on this authorization or to the extent this Authorization is executed as a condition for obtaining insurance coverage. Patient understands that NewLight Psychiatric Services shall not condition treatment, payment, or enrollment in a health plan or eligibility for benefits (if applicable) on whether patient provides Authorization for the requested use or disclosure. I understand that all my medical treatment and psychiatric records are confidential and will be treated as such. In consideration of this consent, I hereby release the above parties from any and all liabilities arising therefrom.

_____ _____

Patient / Authorized Representative Signature Date