CGP
CENTER FOR GREEN PSYCHIATRY, PLLC

CGP Release of Information Form

I authorize the sending and receiving of information between Center for Green Psychiatry, PLLC, and the following:

1. _____

2. _____

3. _____

4. _____

This information may be used by the recipient for treatment, mental health history, records (including substance use history), medical history including infectious disease history, consultation, billing, claims, payment(s), or other purposes as we may direct, unless otherwise specified in the comments/restrictions space below.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. This release authorizes all providers affiliated with CGP as well as covering providers/administrators from other clinics in the event that my CGP provider is out of the office. I understand that there are certain circumstances including but not limited to a health or medical emergency when protected health information may be disclosed without my consent.

If there are any restrictions to information that may be shared, please specify in the comments below. The terms of this ROI are indefinite unless otherwise specified.

Comments/restrictions (if applicable):

_____ / / _____

Patient's Printed Name — Patient's Date of Birth

_____ _____/____/_____

Patient's Signature (Guardian's Signature if patient is under 18 yrs. Old) — Today's Date

_____

Printed Name of Parent or Legal Guardian