PSYCHIATRIC ASSOCIATES
LLOYD BELLAH, M.D.
ALYCIA BELLAH, M.A., LPC
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Consent to Obtain or Release Information

I________________________________, SS#________-_______-________, DOB______/______/_____
Understand that the information obtained in medical records are confidential. However, I specifically give my consent for Dr. Bellah, Alycia Bellah, LPC, Kathryn Thomas, LPC, and/or Emily Downs, LPC, LMFT to release and / or obtain the following medical records or information:

❍ Psychiatric ❍ Substance Abuse Treatment ❍ Insurance Information ❍ Coordination of Patient Care
❍ and/or medical information: ❍ Discharge Summary ❍ Lab Reports ❍ Office Chart Notes
❍ Psychiatric Eval. ❍ History & Physical ❍ X-Ray Reports ❍ Consultations
❍ Other:____

To/From____________________________________Phone #:_________________Fax#:_______________

At the following address: ____

I was treated _____________(approx. dates) for (circle one) inpatient/outpatient care. The above listed information is to be disclosed for the specific purpose of medical evaluation and, or coordination of Patient care.

By written request, this consent may be revoked at any time up to the time that action is taken. The consent will automatically expire upon completion of this transaction and no later than one (1) year from the date signed unless otherwise stated herein.

It is further understood that the information released is for professional purpose only and should not be provided in whole or part to any other agency, organization, or person other than stated above.

I understood that treatment services are not contingent upon my signing or not signing this consent form. I freely and voluntarily give my consent for the release of information from my medical record.

For Substance Abuse Treatment Only: TO THE PARTY RECEIVING THE INFORMATION: This information has been disclosed to you from records whose confidentiality may be protected by federal law. Federal regulations (42 CFR, part 2) prohibits you from making further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. FOR PATIENT RECORD APPLICABLE UNDER LAW 42 CFR PART2.

______________________________ ______________________________
WITNESS SIGNATURE OF PATIENT

______________________________ ______________________________
DATE OTHER NAMES PATIENT MAY KNOWN AS (Maiden or other Married Names)