ADVANCED PSYCHIATRIC GROUP
APG RESEARCH, LLC.

MAIN OFFICE
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APG RESEARCH, LLC.
721 N MAGNOLIA AVE . ORLANDO FL . 32803
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RELEASE OF RECORDS

Authorization to use & disclose Protected Health Information (PHI)

I _____ , DOB ____ / ____ / ____ hereby authorize Advanced Psychiatric Group, P.A. to:
(PATIENT NAME / PARENT / GUARDIAN)

If minor, child name: _____ , DOB ____ / ____ / ____

◯ ***RELEASE*** RECORDS TO ◯ ***OBTAIN*** RECORDS FROM ◯ Verbal Communication Only

PERSON: _____
FACILITY: _____
ADDRESS: _____
CITY: _____
STATE: _____ TEL: _____
ZIP: _____ FAX: _____

THE FOLLOWING INFORMATION:
☐ Complete copy of medical records
☐ Lab results
☐ Psych evaluation / Progress notes
☐ OTHER: _____
☐ Medical report
☐ Letters containing PHI
☐ Billing records

FOR THE PURPOSE OF:
☐ Continuity of care
☐ Settle Insurance Claim
☐ Assist with legal issues
☐ OTHER: _____
☐ Complete disability forms
☐ Spouse / Other: _____
☐ Parent / Guardian: _____

I understand and agree that this authorization will be valid and in effect until _____
(ENTER A DATE OR EVENT UPON WHICH AUTHORIZATION EXPIRES)

I understand that after that date or event, no more of this information can be used or released to the person or organization unless I sign a new authorization like this one. I understand that I can revoke or cancel this authorization at any time by sending a letter to the Privacy Officer of the organization listed above and which is to supply this information. If I do this, it will prevent any releases after the date it is received but cannot change the fact that some information may have been sent or shared before that date. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment from the professional or facility listed above, nor will it affect my eligibility for benefits. I understand that I may inspect and have a copy of the health information described in this authorization, and that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above my be re-disclosed and no longer protected by those regulations. I understand that this professional or facility will receive compensation for the use or disclosure of my health information. I affirm that everything in this form that was not clear to me has been explained and I believe I understand all of it. I understand that the information I am authorizing for release from my health record may include information about sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol or drug abuse/dependence.

_____ _____
CLIENT SIGNATURE DATE

_____ _____
PRINTED NAME OF CLIENT / PERSONAL REP RELATIONSHIP TO CLIENT

_____ _____
WITNESS SIGNATURE DATE

I ACKNOWLEDGE:
☐ That I have received a copy of this completed form.
☐ I have declined a copy of the form.

TO THE RECIPIENT OF CONFIDENTIAL INFORMATION PROHIBITION ON RE-DISCLOSURE