Jennifer Lancaster, PMHNP-BC
Krystle Mills, PMHNP-BC

Records Release

_____ _____ _____
Last name First name Date of Birth

_____ _____
Address Phone

I Authorize: _____ Release To:_____
Facility Facility

_____ _____
Address Address

_____ _____ _____ _____
Phone Fax Phone Fax

Dates information is to be released: From _____ Through _____ (Check all that apply below)
___ Complete Records ___ Outpatient notes ____Labs ____ Emergency notes
___ Medication list

New Patients Only – Please list current insurance plans:
Primary insurance/ID Number: _____ Subscriber Name/DOB: _____
Secondary insurance/ID Number: _____ Subscriber Name/DOB: _____

_____ **If we are obtaining medical records from your previous provider, please check here**

Reason for disclosure of medical records (check all that apply below)
___ Legal investigation/Action ___Moving out of area ___ Further medical care
___ Specialist being seen ___ Age ___ Insurance change ___ Personal ___ Transfer of care
___ Asked to leave

**If transferring to another provider, what is your reason for leaving: _____
_____

The charges for medical records via mailed flash drive or faxed to another provider are as follows: $30

I understand the following:

- I may revoke authorization in writing at any time; this revocation will not apply to information that has already been released in response to this authorization
- The information disclosed in response to this authorization may be subjected to re-disclosure by the recipient and will no longer be protected under the terms of this authorization

- I have the right to inspect or copy the health information to be used or disclosed as permitted by law
- I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, or my eligibility for benefits (if applicable)
- Empowering Minds Behavioral Health PLLC may receive compensation for medical records for by copying them in accordance with PA law, 42 Pa.C.S. 6152, 6152.1, and 6155

I understand that this consent will expire 90 days from the date below

_____ _____
Guardian, parent, or patient 14 years or older signature Date

_____ _____
Printed Name Relationship to patient

I authorize the release of psychiatric/psychotherapy records, mental health records, and drug and alcohol information or treatment records under the same terms and conditions.

_____ _____
Guardian, parent, or patient 14 years or older signature Date

_____ _____
Printed Name Relationship to patient

_____ _____
Witness Date

Important Information that you should know:

Our fax number is : _____
Our email is: _____