

MEDICAL LETTER REQUEST

PATIENT NAME: _____ **DOB:** _____

I hereby authorize disclosure of my medical information to/from the named individual or organization listed below. Please fully complete the form. **Incomplete forms will be null and void.**

Purpose for disclosure: _____

RECIPIENT

FULL NAME TELEPHONE NUMBER

ADDRESS

EMAIL FAX NUMBER

- I understand that specific information to be disclosed may include Drug, Alcohol Abuse or Mental Health Treatment, information regarding communicable diseases including Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency Syndrome (AIDS), and other medical conditions, laboratory results, treatment and any other such related information.
- I understand that the information released pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA privacy regulations.
- I authorize that a photocopy of this authorization is acceptable as an original.
- This authorization will remain in effect indefinitely unless revoked in writing. I understand that my treatment is not conditioned upon my providing this authorization. I understand that I have the right to revoke this authorization at any time by providing a written notification to: The Privacy Officer, Innova Psychiatric Group, 4510 Medical Center Drive, Suite 208, McKinney, TX 75069. Innova Psychiatric Group shall not be deemed responsible for release of any information pursuant to this authorization prior to revocation.
- I understand that there will be a charge of **\$25.00** for each letter requested.

NAME: _____ RELATIONSHIP TO PATIENT: _____

SIGNATURE: _____ DATE: _____
(Ink signature only- digital signature not accepted to complete request) (Must be dated to complete request)

PLEASE SEND LETTER WITH THE BELOW REQUEST INFORMATION TO THE ABOVE-NAMED INDIVIDUAL OR ORGANIZATION.

- DIAGNOSIS
- SYMPTOMS
- MEDICATION LIST
- SIDE EFFECTS OF MEDICATION
- ACCOMODATIONS REQUESTED
- OTHER (Please Specify)

A charge of \$25.00 will be added to your account and payable at time of request or before any future appointments.