Bluebonnet Family Psychiatry

25420 Kuykendahl Rd, The Woodlands, TX 77375

832.520.2450 Bluebonnetpsychiatry.com

Release of Patient Information

Patient Name:_____ Date of Birth:_____

I authorize Bluebonnet Family Psychiatry to: Release / Receive from (Check one or both)

Name or Entity: _____

Address: _____

Phone: _____ **Fax:** _____

Reason for release of patient information: ☐ Medical Records ☐ Coordination of Care ☐ Change Providers

Other: _____

_____

Begin Request Date: _____ End Request Date: _____

The date, extent or condition upon which this authorization expires is to not exceed 12 months, unless indicated above. Furthermore, I understand that I may recant this authorization at any time by written notice.

I understand that this authorization may include information regarding services and treatment received by Bluebonnet Family Psychiatry and staff, including treatment and testing for drug or alcohol abuse. This authorization is valid for the dates listed above unless otherwise indicated. I hereby release Bluebonnet Family Psychiatry and its personnel from all legal responsibility that may arise from the act that I have authorized above. Bluebonnet Family Psychiatry is not responsible for completeness, legibility or omissions used by the copying of any medical records from another institution.

_____ _____

Signature of Patient or Legal Ward Printed name of Patient or Legal Ward