Office: _____

PsyCare

A professional medical corporation
A comprehensive behavioral healthcare system
HEADQUARTERS
4550 Kearny Villa Road, Suite 116
San Diego, CA 92123
(858) 279-1223
Fax (858) 467-6933

Account #: _____

Staff Initials: _____

Waiver Of Responsibility
ADULTS ONLY

Provider(s): _____

Patient Name: _____ **Date of Birth**: _____

I, _____ am getting a copy of my chart because I have instructed PsyCare that I must have a copy of my medical records.

I understand that the medical records and information being released to me, may contain information pertaining to mental health/psychiatric, drug, and/or alcohol related evaluation and/or treatment, genetic/familial information, and confidential HIV (AIDS) related information, including educational, psychological and laboratory tests. I have been informed that the contents of the chart contain highly confidential, sensitive information and that I should maintain the chart in a secured and confidential area.

I understand that this is not an authorization for release of information to third parties. It is the policy of PsyCare to release records, with proper authorization to HIPPA-compliant entities, also bound to the protection of confidentiality of medical records. It is also the PsyCare practice to recommend against the release of medical records to persons or entities not bound by the same laws of confidentiality protection.

PsyCare, as Custodian of Records, will remain in compliance with the terms of the Confidentiality of Medical Information Act of 1981, sections 56, et Seq, California Civil Code, for all original medical records.

I understand that as I take possession of a copy of my medical records, I am responsible for its contents, and take full and complete responsibility for any consequences that may result from my possession of my records. I concurrently release PsyCare from any and all responsibility and liability for consequences to taking possession of a copy of my medical records.

_____ Signed: _____
Date (Patient/Client's Signature)

OFFICE USE ONLY (to be completed before submitting request to Admin):

- ☐ **MD'S ONLY- Consent to release _____**
- ☐ **Therapist's Initials (Pt. seen Individually) _____**
- ☐ **Fee Collected (staff initials) _____**

☐ **SEND FROM OFFICE** ☐ **SENT FROM ADMIN.**

ADMINISTRATION BOX:

☐ **OK-Obtain copy of medical records**

_____ _____
Administrative Signature Date

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Authorization to Release Information

I hereby authorize _____

to release: **All psychiatric/psychotherapy records to patient.**

Regarding:_____ D.O.B. _____

(Patient/ Client's Name) (Patient/ Client's Date of Birth)

Patient Address:_____

Purpose of release: (mandatory)_____

This authorization for use or disclosure of medical information, is being authorized by me giving PsyCare, Inc. permission to disclose medical/psychiatric records and information obtained in the course of the diagnosis and/or treatment of my child or me. This disclosure of medical/psychiatric information complies with the terms of the Confidentiality of Medical Information Act of 1981, section 56, et. Seq, California Civil Code. **I understand that the medical records and information to be released may contain information pertaining to mental health/psychiatric, drug and/or alcohol related evaluation and/or treatment, genetic/familial information and, confidential HIV (AIDS) related information, including educational, psychological and laboratory test results._____(Initial Here)**

The disclosure of information authorized by this consent is required for the purpose of evaluation and treatment. Such disclosure shall be unlimited or limited to the following specific information:

Entire Chart

I may revoke this consent at any time except to the extent action has been taken in reliance upon this consent. If it is not earlier revoked, this consent shall terminate without express revocation one year from date shown below.

_____ Signed: _____

(Date) (Patient/Client's Signature)

OFFICE USE ONLY (to be completed before submitting request to Admin):

- ☐ **MD'S ONLY- Consent to release** _____
- ☐ **Therapist's Initials (Pt. seen Individually)** _____
- ☐ **Fee Collected (staff initials)** _____

☐ **SEND FROM OFFICE** ☐ **SENT FROM ADMIN.**

ADMINISTRATION BOX:

☐ **OK-Obtain copy of medical records**

_____ _____

Administrative Signature Date