SERENITY
Psychiatric Outpatient, LLC

Consent to Release or Obtain Information

Date: _____

Patient Name: _____

Birth Date: _____

Social Security No: _____

I hereby authorize Serenity Psychiatric Outpatient, LLC to Obtain/Release written or oral information from my records or reports From/To:

_____

Address: _____

Phone: _____ Fax: _____

I specifically consent to the release of information stated below, relating to services provided from _____ to _____

☐ Face Sheet ☐ Social Assessment ☐ Report ☐ Treatment Plan

☐ Psych Evaluation ☐ Diagnosis List

☐ Clinical Summary ☐ Other: _____

for the purpose of: ☐ Continuity of Care

☐ Other: _____

I understand that my health information is protected by law. I authorize the release of my confidential health information as indicated above. I understand that my consent is voluntary and I can revoke this permission at any time, except to the extent that it has already been shared based on this authorization.
Should I choose to revoke this authorization I will state this in writing.

Patient: _____ Date: _____

Witness: _____ Date: _____