SOLARA
MENTAL HEALTH
Psychiatry and Medication Management

Facility Address: _____
Phone: _____ Fax: _____
Patient Name: _____
Date of Birth: ___ / ___ / _____

SELECT FROM THE FOLLOWING OPTIONS BELOW:

☐ I authorize the release of medical information FROM **Solara Mental Health**.

☐ I authorize the release of medical information TO **Solara Mental Health**.

RELEASE APPLIES TO INDIVIDUAL OR CORPORATION:

Name: _____
Address: _____
City: _____ State: _____ ZIP Code: _____
Phone #: (____) _____ Fax #: (____) _____

☐ My entire medical records pertaining to my mental health including therapy notes.

☐ My entire medical records pertaining to mental health excluding therapy notes.

From Date of Service: ___ / ___ / _____
To Date of Service: ___ / ___ / _____

PURPOSE:

☐ Personal Records ☐ Continue Care ☐ Legal ☐ Insurance

☐ Medications ☐ Progress in Treatment ☐ Diagnosis

☐ Other (specify): _____

I understand that:

If the person or entity receiving my health information is not covered by privacy laws, my information may no longer be protected.
I may refuse to sign this form & refusal won't affect my treatment or benefits.
I have the right to inspect or copy any information disclosed..
I have the right to revoke this authorization in writing, except to the extent action has already been taken.
Solara Mental Health and its employees are released from liability for the authorized disclosure.
I may request a copy of this signed form.

Print Name of Patient: _____
Date: ___ / ___ / _____

Patient Signature: _____
Date: ___ / ___ / _____

Parent/Guardian Signature (if applicable): _____
Date: ___ / ___ / _____

Witness: _____
Date: ___ / ___ / _____