JAMIE WINDERBAUM FERNANDEZ, MD, PA

INTERVENTIONAL PSYCHIATRY OF TAMPA BAY

Patient Medical Release Form

Date: _____

Patient Name: _____
Date of Birth: _____
Address (Mailing): _____
Phone: _____

I, _____, authorize Interventional Psychiatry of Tampa Bay to use or disclose information from my mental health record, which may include information about psychiatric diagnosis and treatment and substance abuse issues to:
Name: _____ Phone _____
Address: _____ Fax _____

Dates of Treatment: _____
Information to be released (Please describe) _____
Purpose of Disclosure _____

1. I understand that, unless withdrawn, this authorization will expire 180 days from the date of signature. A photocopy of this form will be considered as valid as the original.
2. I understand that I may revoke this authorization at any time by notifying the facility at the address indicated above, in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information and mental health information.
4. I understand that my refusal to sign this Authorization will not jeopardize my right to obtain present or future treatment for psychiatric disabilities except where disclosure of the information is necessary for the treatment.
5. My health care and payment for my health care at Interventional Psychiatry of Tampa Bay will not be affected if I do not sign this form.
6. I understand that I can request a copy of this form after I sign it.
7. I understand that there may be a fee associated with the printing and/or mailing of this information.

By signing below, I acknowledge that I have read and understand this Authorization.

Signature of Patient: _____ Date: _____
Patient Name: _____

** Note: All signatures are required.*

Please call 813-251-1800 or email us at info@interventionalpsychiatrytb.com with questions.
Fax the completed form to 813-251-9422 or email jwf@interventionalpsychiatrytb.com.