Buckeye Psychiatry, LLC

I authorize Buckeye Psychiatry, LLC to have my protected medical records:

☐ sent to ☐ obtained from ☐ discussed with

Doctor/Facility/Business Name

_____

Address

_____

_____

_____

Phone Number

_____

Fax Number

_____

Patient Name

_____

Date of Birth

_____

Social Security Number

_____

Reason for Disclosure

_____

I understand that I have a right to revoke this authorization; I must do so in writing and present my written revocation to Buckeye Psychiatry, LLC. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire 90 days from the date of signing.

_____ _____

Signature of Patient or Legal Guardian **Date**

_____ _____

Signature of Witness **Date**