

**RELEASE OF PROTECTED INFORMATION TO PATIENT**

**HARRIS PSYCHIATRIC SERVICES, PLLC**

Please read and complete this form if you are requesting that Harris Psychiatric Services, PLLC provide you (the patient / guardian) with a copy of your protected health information.

Note that your documents contain sensitive information that should be safeguarded. We advise against sharing your psychiatric records with anyone other than family members, guardians or other healthcare providers.

Please be specific as to what you are requesting. For example: a report from an appointment on a certain date or a copy of a specific letter written by the provider. If you are requesting documents for your own, personal record keeping, please state that as the purpose for release.

Keep your records in a secure location and be sure that the document is properly destroyed (shredded) upon discarding.

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ date of birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ am requesting that a copy of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ be released to me (patient/guardian) to be used for the following purpose \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. I have been instructed as to the proper storage and disposal of the documents.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGNATURE

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME DATE