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[ClientName]

Release of Information (ROI)

I, _____, hereby authorize, to render treatment, release/receive information and medical records to/from any/all providers/health care providers/physicians, insurance carriers, submit claims to my insurance company on my behalf, appeal claims denied by my insurance company on my behalf, release/receive information/records to/from attorney or employer concerning myself or my dependent's illness/injury/condition and treatment. I hereby assign to the provider all payment for medical services rendered to myself or my dependents.

Full Name: _____

Date of Birth: _____

Social Security #: _____

Informed Consent: A patient (or parent/guardian) has the right to ask questions about what type of treatment will be received and discuss with the therapist the potential risks and benefits of each specific recommendation. A patient (or parent/guardian) has the right to decline any portion of treatment at any time during the treatment sessions. I acknowledge that I understand the benefits and risks of therapy services as outlined above and I wish to proceed with assessment and/or treatment.

I also give the members of the clinical treatment team permission/authorization to release, share, and exchange information regarding my progress with treatment goals and objectives, including any additional information deemed relevant to my treatment and rehabilitation with _____, to collaborate, coordinate, and facilitate services and treatment.

I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

Spouse: _____

Child(ren): _____

Other: _____

This document shall be effective for 1 year after date indicated. Any photocopy of this document shall serve as the original.

PATIENT OR LEGAL GUARDIAN Signature

Date