RELEASE OF INFORMATION FORM

PATIENT INFORMATION

PATIENT NAME	DATE OF BIRTH
ADDRESS	**PHONE NUMBER**

By signing below, I, the patient, hereby authorize and agree that Dr. Michael Ingram and MTI Psychiatry, Inc. may discuss and/or disseminate my personal health information (PHI) to, and receive that information from, the following individuals and/or entities: (if none, write "none")

Specify what information Dr. Michael Ingram and MTI Psychiatry, Inc. may disclose, receive, share, and/or discuss with the individuals or entities identified above by checking the corresponding boxes below.

☐ **All health information**	☐ **Progress notes**
☐ **Consultation reports**	☐ **Diagnostic test reports**
☐ **History/physical exam**	☐ **EKG/cardiology reports**
☐ **Mental health records**	☐ **Lab results**
☐ **Past/present medications**	☐ **Radiology reports and images**
☐ **Patient allergies**	☐ **Billing information**

I, the undersigned, understand I may revoke this authorization at any time by providing written notice to Dr. Michael Ingram. I understand that the revocation will not apply to information that has already been released in response to this authorization.

Unless previously revoked in writing, this consent will terminate in 60 days following the completion of services.

I, the undersigned, understand that authorizing the disclosure of information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure, that the information may not be protected by federal confidentiality rules, and that Dr. Michael Ingram and MTI Psychiatry Inc., are not liable for any such redisclosure. Finally, I understand that Dr. Michael Ingram may refuse to share my information with the authorized individuals/entities named above if, in Dr. Michael Ingram's discretion, doing so would not be in my best interest. If I have questions about disclosure of my information, I can contact Dr. Michael Ingram and/or MTI Psychiatry, Inc.

I, the undersigned, have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand and accept the terms and conditions of this authorization.

PATIENT SIGNATURE	**DATE**

GUARDIAN/REPRESENTATIVE SIGNATURE *(If applicable)*	**RELATIONSHIP TO PATIENT**	**DATE**