GRACE PSYCHIATRIC SERVICES

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Please print.

_____

Patient Name | Other Last Names

_____

Date of birth | Phone Number | Email Address

_____

Street Address | City, State, Zip code

Transfer of care is required due to the closing of my physician's office. Therefore, I hereby authorize.

Morgan Records Management LLC, 159 Frontage Rd, Manchester, NH 03103,

on behalf of**, Grace Psychiatric Services, 609 W. Iris Drive, Nashville, TN 37204,** to execute one of the following:

Please select one of the following delivery options:

☐ Secure HIPAA approved electronic transfer **$25.00**: **List email you want chart sent to here:**

_____

☐ Disk Mailed to Home or Physician - USPS Certified Return Receipt: **$35.00**: **List address you want disc mailed to here:**

_____

I, _____, am the patient or legal guardian who has authorization to release the above records. Any facsimile, copy, or photocopy of this release will be valid for 90 days and shall authorize you to forward my medical records. This form gives you permission to share my private information obtained from this facility. Only records from this facility can be legally released. Any records from other physicians must be obtained from them directly.

Payment Options:

- **CREDIT CARD** – please use our online form: MorganRM.Com-> Medical Records tab-> Request My Records
- **CHECK** - please mail your completed authorization form with an attached check or money order made payable to Morgan Records Management LLC, to 159 Frontage Rd, Manchester, NH 03103.

_____

Patient or Legal Guardian Signature | Date

Your completed authorization form may be faxed to 603-606-1126, emailed to Medical@MorganRM.com, or mailed to Morgan Records Management LLC, 159 Frontage Rd, Manchester, NH 03103.