FERMO
Psychiatric Solutions
INC.

Ricardo J. Fermo, MD
Diplomate, American Board of Psychiatry and Neurology
Diplomate, American Academy of Child and Adolescent Psychiatry
Fermo Psychiatric Solutions, Inc.
Creekside Corporate Center
887 Johnnie Dodds Blvd., Suite 100
Mount Pleasant, South Carolina 29464-3145
Office Telephone: (843) 856 6998
Office Fax: (843) 856 6997
www.fermopsych.com

Authorization for the Release of Protected Health Information

PATIENT NAME: _____ DATE OF BIRTH: _____

Note: Any requests for records to a person/organization other than a health care facility or insurance company, in order to obtain health care services or insurance coverage is subject to a **fee of $25.00 copy/service plus $00.25 per page.**
I authorize the release and disclosure of my Protected Health Information between Dr. Ricardo Fermo and his staff below or attach a business card:

Person/Organization _____

Street _____

City, _____ State _____ Zip _____

Phone: _____ Fax: _____

☐ RELEASE MY RECORDS ☐ OBTAIN RECORDS ☐ Keep on file for communication, but DO NOT send or obtain my records

☐ Send a letter notifying them of my diagnosis and treatment ☐ Other: _____

The type and amount of information to be used or disclosed is

☐ All Records ☐ Lab Results ☐ Treatment/Visit Notes ☐ Medication List ☐ Test Results

☐ Discharge Summary ☐ Other: _____

Purpose of Release

☐ Coordination/Continuity of Care ☐ Transfer Care ☐ Insurance ☐ Legal ☐ Personal

☐ Other: _____

Release of Information

I authorize release of information to my Primary Care Physician, other health care providers, institutions, and referral sources for the purpose of diagnosis, treatment, consultation and professional communication. If I am an insured client, I further authorize the release of information including diagnosis for pharmacy prior certification, claims, certification, case management, quality improvement, benefit administration and other purposes related to my health plan. I understand that my Protected Health Information may contain information relating to Sexually Transmitted Diseases, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and other communicable diseases, Behavioral Health Care/Psychiatric Care, treatment of alcohol/drug abuse and genetic testing.
I understand that the information released may no longer be protected by state and federal regulations and may be re- disclosed by the recipient of the information.
I understand that I may revoke this authorization, in writing to Dr. Ricardo Fermo, except to the extent that action has already been taken according to the authorization.
I understand that the authorization will expire 1 year from the date signed, if not revoked, or as specified: _____
I release Dr. Ricardo Fermo and his staff from any legal liability for the release of information in accordance to the above authorization.

Signature/date: _____

Witness/date: _____