shrink.
PSYCHIATRY · MATTHEW SLATTERY, MD

315 Metairie Road, Suite 300 · Metairie, LA 70005
504-429-8801 · shrinkpsychiatry.com

FOR DR. RYNNING'S PATIENTS

Authorization to Release Medical Records

From Jon Rynning, MD to Matthew Slattery, MD at Shrink Psychiatry

How to use this form

1. **Fill in and sign this form.** Type into it on a computer, or print it and use a pen.
2. **Give or email it to Dr. Rynning's office.** It tells them which of your records to send to Dr. Slattery.
3. **Keep a copy, and send one to us.** Bring it to your first visit or send a photo of it in a patient portal message, and we'll keep it in your chart.

01 About you

FULL NAME

DATE OF BIRTH

PHONE

EMAIL

OTHER NAMES USED AT DR. RYNNING'S OFFICE (OPTIONAL)

02 Who releases the records, and who receives them

RELEASE FROM

Jon Rynning, MD, his office, and any custodian of his medical records

RELEASE TO

Matthew Slattery, MD
Shrink Psychiatry (M Slattery MD LLC)
315 Metairie Road, Suite 300, Metairie, LA 70005
504-429-8801 · inbox@mail.shrinkpsychiatry.com

03 Records to release

☐ **My complete record** (everything below, except psychotherapy notes)

☐ **Only the records I check here:**

- ☐ Psychiatric evaluations and progress notes
- ☐ Diagnoses and treatment plans
- ☐ Records from other doctors or hospitals
- ☐ Medication list and prescription history
- ☐ Lab and other test results
- ☐ Other:

Dates of service: ☐ All dates ☐ Only from _____ to _____

Specially protected information. State and federal law need your specific permission to release these. Write your initials next to any you want included; anything you leave blank is not released.

_____ HIV/AIDS testing or treatment _____ Alcohol or drug use treatment _____ Genetic testing

Psychotherapy notes (notes some therapists keep separately from the medical record) need their own authorization and are not released with this form.

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04 Purpose

To continue my psychiatric care with Dr. Slattery, at my request.

05 How long this authorization lasts

This authorization ends one year after the date I sign it, unless I write an earlier date or event here:

06 I understand that

- I can cancel (revoke) this authorization at any time by writing to Dr. Rynning's office or the custodian of his records. Cancelling does not undo a release made before my written notice was received.
- Signing is my choice. Dr. Rynning and Dr. Slattery will not condition my treatment, payment, enrollment or eligibility for benefits on whether I sign.
- Once records are released, the person receiving them could share them again, and they may no longer be protected by federal privacy law. Dr. Slattery keeps them confidential as part of my medical record.
- I may look at or get a copy of the information to be released, and I am entitled to a copy of this signed form.

07 Signature

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE

DATE

PRINTED NAME

If a personal representative signs (for example, the parent of a minor, a legal guardian or someone with power of attorney), describe your authority:

FOR OFFICE USE

Dr. Rynning's office

Records released on

Released by

Notes

Shrink Psychiatry

Form received on

Added to chart in Hero on

Initials

Shrink Psychiatry · Matthew Slattery, MD · 315 Metairie Road, Suite 300, Metairie, LA 70005 · 504-429-8801 · inbox@mail.shrinkpsychiatry.com. If you are in crisis, call or text 988 or go to the nearest emergency room.