AUTHORIZATION TO USE OR RELEASE PERSONAL HEALTH INFORMATION

Patient Name:

1. I, _____, hereby authorize _____
[name of patient] [name of psychiatrist]

to release the health care information described below to:

Name: _____

Entity: _____

Address: _____
[individual or entity to receive information]

2. This request and authorization applies to only the following protected health information:

_____

_____

_____
[description should be as specific and detailed as possible]

3. List each purpose or reason for the use or release of the protected health information:

_____

_____

_____

4. This authorization shall remain in full force and effect until _____
_____
[expiration date or expiration event related to the individual or the purpose of use or disclosure]

5. I understand that, except with respect to action already taken in reliance on this authorization, I may revoke this authorization in writing at any time by delivering or sending written notification to
_____.

[name and address or email address of authorized person]

6. I understand that signing this authorization is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits will not be conditioned upon my authorization of this disclosure.

7. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws. If this authorization is for the release of HIV-related information, the recipient of the information is prohibited from redisclosing any HIV-related information about you without your authorization unless permitted to do so by federal or state law.

8. I understand that I have the right to receive a copy of this authorization after I have signed it. I understand that a copy of this authorization will be maintained in my patient record.

9. I understand that I have the right to refuse to sign this authorization.

Please sign below to authorize the use or release of your personal health information for the reasons set forth above:

_____

Signature of Patient or Patient's Personal Representative, if applicable

_____

Date

_____

Name of Patient or Patient's Personal Representative, if applicable

_____

Description of Authority of Patient's Personal Representative, if applicable

Revised 3/25/14