Changing Tides Psychiatry

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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I authorize my physician and/or administrative and clinical staff to use or disclose the following protected health information:

_____

_____

Name of entity/class of persons to receive/send information:

_____

_____

Information to be used or disclosed: (Initial beside all that apply)

_____ Initial Assessment
_____ Discharge Summary
_____ Progress Notes
_____ Date of Service: _____
_____ Other(specify): _____
_____ Exchange of information/release of clinical information for coordination of care between above named individuals (telephone and/or written communications).

_____ Radiology Reports
_____ Consultation Reports
_____ Lab Reports

Purpose for use or disclosures: (Select all that apply)

☐ Insurance/Billing ☐ School ☐ Disability ☐ Continuing Care
☐ Legal ☐ Personal ☐ Other: _____

I understand the contents to be released, the need for the information and that there are statutes and regulations protecting confidentiality of authorized information. I also understand that the contents may be subject to facsimile transmission. I acknowledge that the information may contain sensitive material, such as, but not limited to my condition relating to HIV status, drug use or alcohol abuse or psychiatric or psychological information.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's privacy officer. I understand that this authorization will expire **one year** from the date of its being signed by me. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if any authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand the information used or disclosed, pursuant to this authorization may be disclosed by the recipient and may no longer be covered by federal or state law.

My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except (1) if any treatment is related to research or, (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

The use or disclosure requested under this authorization may result in direct or indirect remuneration to my physician from a third party (if applicable).

X _____ X _____
Patients Name - please print — Date of birth

X _____ X _____
Signature Patient or personal representative-relationship — Date