Community Psychiatry

Authorization for Use or Disclosure of Health Information

Patient Information

Patient Name: _____
Date of Birth (mm/dd/yy): _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone Number: _____ Email Address: _____

Recipient of Health Information

I hereby authorize **Community Psychiatry, its staff and providers,** to:

☐ Disclose to
☐ Request from

Person/Organization: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone Number: _____ Fax Number:_____

Purpose of Disclosure

The purpose of the disclosure of my health information is:

☐ Care coordination ☐ Treatment planning ☐ Legal
☐ Billing/payment activities ☐ Personal use
☐ Other *(specify):* _____

Information to be Disclosed

I authorize the following information to be disclosed:

☐ All of my health information and records, including, my medical and mental health history, lab results, diagnoses, treatment and prescriptions *(excluding psychotherapy notes, for which a separate disclosure authorization must be obtained)*

OR

☐ Only the following information *(specify):* _____
_____

I authorize the disclosure of the following **specially protected health information** *(check and initial all that apply):*

- ☐ Inpatient/residential mental health treatment information Initials: _____
- ☐ Alcohol/drug treatment records Initials: _____
- ☐ HIV/AIDS test results Initials: _____
- ☐ Genetic test results Initials: _____
- ☐ Pregnancy test results Initials: _____
- ☐ Abortion Initials: _____
- ☐ Sexually transmitted or other communicable diseases Initials: _____

Expiration and Revocation

This Authorization will expire on the date that is five (5) years from the date of my signature below.

I understand that I may revoke this Authorization at any time by notifying Community Psychiatry in writing, except to the extent Community Psychiatry has already taken action in reliance on this Authorization.

Signature

I have read this form and I understand and agree to its terms. I authorize Community Psychiatry to disclose the information identified above.

I understand that Community Psychiatry cannot condition my treatment, payment, enrollment or eligibility for benefits on my provision of this Authorization. I understand that information disclosed pursuant to this Authorization, except for alcohol/drug treatment records protected by 42 CFR Part 2, may be subject to redisclosure by the recipient and no longer protected by HIPAA. I understand that I have the right to receive a copy of this Authorization.

_____ _____

Patient Signature Date

If you are signing this Authorization as a legal or personal representative of the patient, please indicate your authority to act on behalf of the patient and sign below.

- ☐ Parent ☐ Conservator ☐ Power of Attorney for Health Care
- ☐ Guardian ☐ Health Care Surrogate ☐ Executor/Administrator

_____ _____

Signature Date

_____

Name