# Authorization for Use or Disclosure of Health Information

## Patient Information

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Date of Birth (mm/dd/yy):</th>
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<tbody>
<tr>
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<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>City:</td>
<td>State:</td>
</tr>
<tr>
<td></td>
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</tr>
<tr>
<td>Phone Number:</td>
<td>Email Address:</td>
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</tbody>
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## Recipient of Health Information

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

- [ ] Disclose to
- [ ] Therapist
- [ ] Primary Care
- [ ] Request From
- [ ] Past Psychiatrist
- [ ] Other:

Person/Organization: ______________________________________________________

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<table>
<thead>
<tr>
<th>City:</th>
<th>State:</th>
<th>Zip Code:</th>
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<tr>
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<th>Fax Number:</th>
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## Purpose of Disclosure

The purpose of the disclosure of my health information is:

- [ ] Care Coordinator
- [ ] Treatment Planning
- [ ] Legal
- [ ] Billing/Payment Activity
- [ ] 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: ____________________________________________
I authorize the disclosure of the following specially protected health information (check and initial all that apply):

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

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:__________________________________________