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, it's staff and providers to:

- ❑ **Disclose to**
- ❑ **Request From**
- ❑ Therapist
- ❑ Past Psychiatrist
- ❑ Primary Care
- ❑ Other:_____

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 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 | 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:_____