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Consent for “Releasing” or “Obtaining” Confidential Medical Information

PLEASE READ THIS FORM THOROUGHLY PRIOR TO COMPLETING IT IN ITS' ENTIRETY.

Patients Name: _____ Birthdate: _____

Parent/Guardian's Name: _____ Patient's S.S. # _____

I hereby freely and voluntarily authorize (Physician Releasing Records) to:

- Verbally release/disclose my protected health information to
- Verbally obtain my protected health information from
- For physical records to be sent or obtained

Physician Releasing Records:

Name: _____
 Address: _____
 City: _____
 Phone: _____
 Fax #: _____

Physician/ Person to Receive Records:

Name: _____
 Address: _____
 City: _____
 Phone: _____
 Fax #: _____

I understand that my medical records may contain information regarding testing, drug, and/or alcohol diagnosis and treatment, a communicable or venereal disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, or the human immunodeficiency virus, also known as acquired immune deficiency syndrome (AIDS) and/or tuberculosis. It may also include information about behavioral or mental health services (Code 42 of Regulations, Part 2). I understand that such information is confidential and is protected by federal law. I understand that the provision of health care treatment to me cannot be conditioned upon my agreement to sign an authorization for the disclosure or use of my health information for purposes other than for treatment, payment, and healthcare operations. I understand that the potential exists for health information that is released with my authorization to be re-disclosed by the recipient, and to be no longer protected by the federal HIPPA law. I understand that I have the right to revoke this authorization at any time by giving written notice (Facility Name) Privacy Officer, except to the extent that action has already been taken in reliance on it. If not previously revoked by me in writing, this authorization is effective on this date and will expire one (1) year following discharge from treatment.

Information to be used or disclosed:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Psychological Intake | <input type="checkbox"/> Progress Report | <input type="checkbox"/> Treatment Plan | <input type="checkbox"/> Diagnosis |
| <input type="checkbox"/> Complete Records | <input type="checkbox"/> Psychological Screening | <input type="checkbox"/> Psychological Testing | <input type="checkbox"/> Therapy Notes |
| <input type="checkbox"/> Medication Reviews | <input type="checkbox"/> Other (explain) _____ | | |

Purpose of disclosure:

- | | | | | |
|--|---|--|--|---|
| <input type="checkbox"/> Insurance Matters | <input type="checkbox"/> Academic Matters | <input type="checkbox"/> Legal Matters | <input type="checkbox"/> Patient Request | <input type="checkbox"/> Progress Updates |
| <input type="checkbox"/> Referral for Services | <input type="checkbox"/> Coordination/ Continuation of Care | | | |
| <input type="checkbox"/> Other (explain) _____ | | | | |

 Patient or Parent/ Guardian Signature

 Date

 Witnessed By

 Date