AUTHORIZATION FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

By signing this form, confidential psychological and psychiatric information can be released to and/or discussed with the people or agencies listed below unless noted by exclusions or limitations. This form is signed voluntarily and may be revoked at any time. All disclosures made pursuant to this form are valid as long as they were made before the date of revocation. This form does not provide for the release of psychotherapy notes, including notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a counseling session.

Patient Information
Patient Name: _____
Patient Date of Birth: _____ (Month / Day / Year)

Authorization
I, the above-named Patient/Legal Guardian, authorize MODERN PSYCHIATRY to: (select all that apply)

- ☐ Disclose information to
- ☐ Obtain Information from
- ☐ Exchange Information: Both disclose information to and obtain information from:

Recipient Information
Name of Person or Organization: _____
Role/Title/Relationship to Patient: _____
Organization/Person Address:
Street Address: _____
City, State, ZIP: _____
Phone Number: _____
Fax Number: _____

Type of Information to be Disclosed
I authorize only the disclosure of the following information:

- ☐ I authorize disclosure of all health information in my medical records, which do not include psychotherapy notes.

Exclusions (if any): _____

Purpose of Disclosure

- ☐ My health information is being disclosed at my request or at the request of my personal representative; OR
- ☐ My health information is being disclosed for the following purpose:

_____

Limitations

Note any exclusions or limitations here:

_____

Understanding of Authorization

I understand that information from mental health clinical records may only be released pursuant to this authorization to the parties identified herein who have a demonstrable need for the information, provided that the disclosure will not reasonably be expected to be detrimental to the patient or another person.

Treatment, payment, enrollment in a health plan, or eligibility for benefits is not dependent on my signing this authorization. By signing below, I acknowledge that I have read and understand this document and that I have voluntarily given MODERN PSYCHIATRY authorization to disclose my records. I understand that I may revoke this authorization at any time by providing a written notice to MODERN PSYCHIATRY; however, the revocation will not have an effect on any actions taken prior to the date my revocation is received.

I understand that my information may be redisclosed by the authorized person/organization receiving the information, and at that point, the information may no longer be protected under the terms of this agreement.

<u>This authorization will expire one year following the date signed unless revoked in writing.</u>

Signature: _____

Date: _____ (Month / Day / Year)

- ☐ Authorization is given on this patient's behalf due to being a minor or unable to sign.

Legal Guardian/Personal Representative Signature: _____

Date: _____ (Month / Day / Year)