# Release of Protected Health Information

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Patient Name:_____ DOB:_____

**1)** I hereby authorize the:

- Disclosure of my protected health information to any and all Providers:

**2)** Please list the name, phone number and type (e.g. therapist, PCP, psychiatrist, NP etc.) of provider(s):

Name & Type of Provider: _____ Phone #:_____

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**3)** The following protected health information is authorized to be disclosed:

- Psychiatric Evaluation
- Treatment Plan / Summary
- Medication List
- Rating Scales
- Daily Treatment Notes
- All of the Above

**4)** Purpose of the Disclosure:

- Continuity/ Coordination of Care
- Disability
- School or Work
- Family member / loved one
- Legal

**5) CONSENT:** I, the undersigned, authorize the release of health information as indicated above. I understand that my records/ protected health information cannot be released until I sign this form. I understand and acknowledge that the requested health 1 information may contain information regarding physical and mental illness, HIV test results or diagnosis, treatment of AIDS/AIDS-related conditions, and/or alcohol/drug abuse. This authorization and consent will expire one year from the date of authorization written below, unless revoked by me (or my legal representative) through written notice presented to this practice's Health Information Management entity. Any revocation will not apply to information that has already been released in response to this authorization. Furthermore, I understand that if the person or entity that receives the above information is not a healthcare provider or intended party covered by federal privacy regulations, the information described above may be redisclosed by such person or entity and will likely no longer be protected by privacy regulations. I understand that treatment, payment, enrollment, or eligibility for benefits will not be based on whether I sign this authorization. I understand that I can refuse to sign this release of information and no information will be shared. Federal Regulations applicable to the protection and release of information are 45C

Signature: _____Date:_____

Relationship if Not Patient:_____

Do you consent to continued follow-up contact from our practice? (e.g., phone calls, emails, or text messages related to your care)? ☐ Yes ☐ No

*If yes, this authorization remains valid until you revoke it in writing.