AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

PATIENT INFORMATION

Patient Name: _____
Date of Birth (mm/dd/yyyy): _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone Number: Email Address: _____

RECIPIENT OF HEALTH INFORMATION

I hereby authorize Geriatric Psychiatry Direct, its staff and providers, to:
□ Disclose to
□ Request from
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 coordination
- ☐ Treatment planning
- ☐ Legal
- ☐ Billing/payment activities
- ☐ Personal use

Other (specify): _____

INFORMATION TO BE DISCLOSED

I authorize the following information to be disclosed:

- ☐ All 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 (specify): _____

_____

I authorize the disclosure of the following specially protected health information (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:_____
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 Geriatric Psychiatry Direct in writing, except to the extent Geriatric Psychiatry Direct has already acted in reliance on this Authorization.

SIGNATURE

I have read this form and I understand and agree to its terms. I authorize Geriatric Psychiatry Direct to disclose the information identified above.

I understand that Geriatric Psychiatry Direct 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

_____ _____
Patient Name Patient Date of Birth

If you are signing this as a parent, guardian or other legal representative of the patient, please indicate your authority to act on behalf of the patient and sign below.

- ☐ Parent
- ☐ Guardian
- ☐ Conservator
- ☐ Health Care Surrogate
- ☐ Power of Attorney for Health Care
- ☐ Executor/Administrator

_____ _____
Signature Date

_____ _____
Patient Name Patient Date of Birth