PSYCHIATRY ASSOCIATES, PC
1736 Oxmoor Road. Suite 103
Birmingham, AL 35209
Telephone: (205) 879-2120. Telecopier: (205) 879-2125

Authorization to Obtain/Disclose Health Care Information

Patient's Name: ____ **Birth date**: _______________

Maiden or other name (if applicable): ____

I request and authorize Psychiatry Associates, PC to obtain from / release to

Name: ____

Address: ____

The following personal health care information (initial to specifically authorize disclosure):

_______ Parent questionnaire
_______ Patient questionnaire
_______ Initial evaluation
_______ Physical/Neurological Examination
_______ Clinical formulation and diagnoses
_______ Progress notes
_______ Hospital admission notes
_______ Discharge summary
_______ Medication record
_______ Outpatient clinical summary
_______ Psychological evaluation
_______ Psycho-educational testing and report
_______ Blood/urine tests (including drug screens)
_______ Clinical diagnostic studies: □ Hearing testing; □ Visual testing; □ EKG; □ EEG; □ MRI/CT Scan
_______ Other (specify): ____

During the following time period or dates: ____

Purpose(s) of this use/disclosure: □ Patient care; □ Request of the individual; □ Other: ______________

Authorization expires: ___________________________ **(date or event, e.g. "end of treatment")**

I understand that, unless action already has been taken in reliance on this authorization, I may revoke this authorization at any time by making a written request to Mrs. Lois Evans, Privacy Officer, or my psychiatrist.

I understand that Psychiatry Associates, P.C. may not condition treatment, payment, enrollment or eligibility for benefits on my signing this authorization, unless my treatment is related to research and the purpose of this authorization is to enable the protected health information described above to be used for such research.

I understand that information disclosed based on this authorization may be subject to subsequent disclosure by the recipient, and no longer protected by federal privacy regulations.

I understand that my express consent is required to release any health care information relating to testing, diagnosis and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health or drug/alcohol treatment or use.

Signature (patient or authorized representative): ____

Relationship/authority (if signed by authorized representative): ______________________________

Date: ______________ I have received a copy of this signed authorization: (please initial) ____YES ____NO