James R. Parks, M.D. PLLC
Child & Adolescent Psychiatry

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Authorization to Release and/or Obtain Health Information

Patient Name:_____ Date of Birth:_____

*Check all that apply

___ I hereby authorize Dr. Parks to ***release*** my medical information to

_____. (Name of Individual or Facility)

___ I hereby authorize Dr. Parks to ***obtain*** medical information from

_____. (Name of Individual or Facility)

Address of Individual or Facility:

_____

Street City State Zip

Telephone of Individual or Facility:_____ Fax:_____ Information to be Released/Obtained: Check all that apply:

	History and Physical		Progress Notes		Consultations
	Discharge Summary		Operative Reports		EKG Report
	Laboratory Reports		Radiology Reports		Outpatient Clinic Records
	Emergency Medicine Report		Other Diagnostic Reports		Immunizations/Vaccinations
	Other:_____				

Specific Authorizations: Check all that apply:
___ I authorize the release of information pertaining to drug and alcohol abuse diagnosis or treatment.
___ I authorize the release of information pertaining to mental health diagnosis or treatment.
___ I authorize the release of HIV/AIDS testing information
___ I authorize the release of genetic testing information.

Purpose of Release/Obtaining Medical Information: Check all that apply:
___ Coordination of Care
___ Continuity of Care
___ Billing and payment
___ At request of client or client representative
___ Other: _____

Effective Date of Authorization:_____Duration of Authorization:_____

Please Note: Dr. Parks, like many other health organizations, physicians, hospitals, and health plans, is required by state and federal law to keep your health information confidential. For full details of Dr. Parks' privacy policies, please refer to the Notice of Privacy Practices. If you do authorize disclosure of your protected health information to an individual or organization who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

My Rights

- I understand this authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization except if the authorization is for: 1) conducting research-related treatment, 2) to obtain information in connection with eligibility or enrollment in a health plan, 3) to determine an entity's obligation to pay a claim, or 4) to create health information to provide to a third party. Under no circumstances, however am I required to authorize the release of mental health records.
- I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Dr. Parks. I understand that the revocation will not apply to information that has already been released in response to this authorization.
- I am entitled to receive a copy of this Authorization.

Signature

_____ Date: _____

Signature of Client or Client's Legal Representative

If signed by someone other than client, please state your relationship to the client: _____

Witness: _____