AUTHORIZATION FOR RELEASE OF MENTAL HEALTH RECORD

I, _____, understand that as part of my healthcare, Peter A. Gold, Psy.D. originates and maintains electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis to my bill,
- A means by which a third-party payer can verify that services billed were provided,
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations.

I understand that an authorization to disclose is a written document signed by me, the patient, giving permission for a health care provider to disclose PHI to specified individuals and/or entities. I understand my authorization to disclose is ***not*** required for the following purposes:

- For the continued or collaborative treatment of a patient between providers,
- For payment of or billing for services,
- For health care operations (for example, quality assurance, credentialing, audits, compliance monitoring)

I understand that the practice is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already acted in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, Peter A. Gold, Psy.D. may be unable to treat me.

I further understand that Dr. Peter A. Gold, Psy.D. reserves the right to change their notice and practices. Should the practice change their notice, they will send a copy of any revised notice to me.

I authorize Peter A. Gold, Psy.D. to disclose information from my mental health record to:

☐ Family Member(s) (enter names and relationships):

_____

☐ You may leave detailed messages on my phone voicemail: Phone Number: _____

By signing below, I acknowledge that I have read and understand this authorization. This authorization will remain in effect until cancelled.

Patient's Signature: _____ Date: _____

Printed Name: _____