Max Psychiatry

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AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Client Name _____ Date of Birth_____

Client Medical Record #_____ Client SS #_____

I _____ hereby authorize
(Client or Personal Representative)

_____ to disclose specific health information
(Name of Provider/Plan)

from the records of the above named client to: _____
(Recipient Name/Address/Phone/Fax)

_____

_____

for the specific purpose(s) (check what applies): ☐ **Continuity of Care/Placement** ☐**Medical/Psychological Evaluation** ☐ **Research** ☐**Coordination of Care & Treatment Planning** ☐ **Legal Proceedings & Investigations** ☐**Referral** ☐**Determination of eligibility for benefits** ☐**Other** _____

Specific information to be disclosed (check what applies): ☐**Treatment Information** ☐**Discharge Summary**

☐ **Verification of Stay** ☐**History & Physical Exam** ☐**Psychiatric Assessment** ☐**School Records** ☐**After Care Plan**

☐**Other information as specified:**_____

I understand that this authorization will expire on the following date, event or condition: _____

_____

I understand that if I fail to specify an expiration date or condition, this authorization is valid indefinitely. I also understand that I may revoke this authorization at any time and that I will be asked to sign the *Revocation form.* I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing this disclosure will include that information. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given. I further understand that I may request a copy of this signed authorization.

_____	_____	_____
(Signature of Client)	*(Date)*	*(Witness-If Required)*
_____	_____	_____
(Signature of Personal Representative)	*(Date)*	*(Personal Representative Relationship/Authority)*