Paloma
Psychiatry and Mental Health

13625 Pond Springs Road, Suite 105, Austin, TX 78729 Phone: (512) 893-1515 Fax: (512) 503-8015

AUTHORIZATION TO DISCLOSE, USE OR RECEIVE PROTECTED HEALTH INFORMATION

Name of Patient or Individual: _____

Other Names Used: _____

Date of Birth: _____

Address: _____

City/State/Zip: _____

Phone: _____

Reason for Disclosure:
(Choose only one option below)

- ▫ Treatment/Continuing Medical Care
- ▫ Personal Use
- ▫ Billing/Claims
- ▫ School
- ▫ Employment
- ▫ Other: _____

I authorize Erica Navaira Buch, APRN, PMHNP-BC/Paloma Psychiatry and Mental Health, PLLC to:

___Disclose ___Use ____Receive protected health information about me with:

Person/Organization Name: _____

Relationship to the Individual/Patient: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

- ▫ All health information
- ▫ Evaluations and Assessments
- ▫ Past/Present Medications
- ▫ Developmental/Social History
- ▫ Lab Results
- ▫ EKG/Cardiology Reports
- ▫ Summary of Treatment (Diagnosis, Treatment Plan, Progress Notes)
- ▫ Other: _____

Your initials are required to release the following information:

_____ Mental Health Records (excluding psychotherapy notes)

_____ Genetic Information (including Genetic Test Results)

_____ Drug, Alcohol, or Substance Abuse Records

_____ HIV/AIDS Test Results/Treatment

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month___Day___Year_____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named above. I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provid- ed by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION VIA EMAIL: I have indicated my preference regarding the sharing of information by email. Risks related to release of information via email include but are not limited to: e-mail can be altered, forwarded, intercepted, printed, and stored by others without detection; unintentional errors in entering email addresses could result in your information being sent to the wrong person.

___yes ____no Email information to be sent to: _____

_____ _____

Signature of Individual or Individual's Legally Authorized Representative **Date**

Printed Name of Legally Authorized Representative (if applicable): _____

If representative, specify relationship to the individual: ▫ Parent of minor ▫ Guardian ▫ Other _____