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INSIGHT PSYCHIATRY INC.

Authorization for use and disclosure of protected information

I, _____
Date of birth: SSN:
Address _____
Phone _____
Authorize:
Name of treatment facility or clinician:

Address: _____

City _____ State _____ Phone _____

To release the following information:
___ Psychiatric Records
___ Substance Abuse Treatment
___ Psychological Testing
___ Records of Psychiatric Hospitalization
___ Medical Records
___ Diagnostic & Laboratory Testing
___ Other _____
___ Other _____

Regarding services rendered during the following dates:

To: Robin Cockrell, MD (Insight Psychiatry, PA)

The purpose of this disclosure is at patient request

I understand that I have a 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 the treatment facility or clinician named above. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurance with the right to contest a claim under my policy.

I understand that this authorization for disclosure is voluntary and that I need not sign this form to ensure healthcare treatment.

This authorization will expire on _____ (if no date is entered it will expire in 12 months from the date signed).

Signed: _____ Date _____

Witness: _____ Date _____