PLAZA WEST PSYCHIATRISTS

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Authorization for Disclosure of Health Information

We need a form completed for each person you would like us to disclose your information to

Medicaid Patients must complete this form for your Primary Care Provider, if you do not have a Primary Care Provider please write None and complete

Patient Name_____ DOB_____/_____/_____

Social Security Number_____ Date of Consent_____

Hereby Authorize: Plaza West Psychiatrists

To Receive _____ To Release _____ Protected Health Information To/From:

_____

Name of Health Care Provider/Agency/Plan/Other

_____ _____ _____

Address City, State, Zip Code Phone Number Fax Number

INFORMATION TO BE DISCLOSED: (please check all that apply)

___ Entire Record ___ Psychiatric Evaluation ___ Laboratory Reports ___ Treatment Plan

___ Psychological Evaluation ___ Consultations ___ Prescriptions ___ Substance Use Assessment

___ History & Physical Examination ___ Termination Summary

___ Other (Specify):_____

REASON FOR DISCLOSURE: (please check all that apply)

___Request of Patient ___Collaboration of Care ___ Legal Purposes ___Consultation and/or Treatment

___ Obtaining past treatment records ___Changing Providers

___Other (Specify) _____

I understand that I may revoke this authorization at any time in writing or it will automatically expire 12 months from the date signed. By signing this Authorization, I acknowledge that the information to be released may include material that is protected by Federal Law and may be applicable to Drug/Alcohol related information. My signature authorizes release of all such information. I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes and I am releasing Plaza West Psychiatrists from all liability resulting from this disclosure. By my signature, I authorize that a photocopy or facsimile (fax) copy shall have the same effect and authority as the original copy.

Signature of Patient/Parent or Guardian_____Date_____

Witness_____