Octaviana Hemmy Asamsama, PsyD, DrPH
Licensed Clinical Psychologist, OHIO (P.O7904) & Maryland (05499)

3665 Erie Ave
Cincinnati, OH 45208

Phone: (513) 273-0450
Email: Dr.OctavianaHemmy@gmail.com

REQUEST FOR AND AUTHORIZATION TO RELEASE MEDICAL RECORDS OR HEALTH INFORMATION

(Also known as Protected Health Information)

PATIENT NAME:_____ Date of birth:_____
Address (Mailing): _____ Phone: _____
_____

I authorize Dr. Hemmy Asamsama (Dr.Hemmy, LLC) to use or disclose information from my mental health record, which may include information about psychiatric diagnosis and treatment. I understand that the information to be released includes information regarding the following condition (s):

☐ DRUG USE ☐ ALCOHOL USE ☐ TESTING FOR OR INFECTION WITH HIV ☐ SICKLE CELL ANEMIA

Name and address, phone, and/or fax number of organization, individual, or title of individual to whom information is to be released.

_____
_____
_____

Dates of treatment: _____
Information to be released (please described): _____
Purpose of disclosure: _____

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules. I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice, and after (some states vary, usually 1 year) this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization. If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

By signing below, I acknowledge that I have read and understand this Authorization.

_____ _____ OR _____ _____
Signature of Patient Date Parent/Legal Guardian/Authorized Person Date

_____ Relationship to Patient