CHARLES P. GENNAULA, M.D.
Specializing in Neurology

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AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Name of Patient ______________________________
Date of Birth ________________ SS# ________________
Daytime Phone # ________________ Evening Phone # ________________
Address ______________________________
City ________________ State ________ Zip Code ________

I hereby authorize ______________________ to use or disclose my protected health information as indicated below to:

Name ______________________________
Daytime Phone # ________________ Fax # ________________
Address ______________________________
City ________________ State ________ Zip Code ________

Information to be released:
From & To Dates ________________
___ History & Physical Exam
___ Lab Report
___ X-ray report
___ Consultation report
___ Other ________________

I understand that this health information may include HIV-related information and or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by signing this form, I am specifically authorizing the release of information relating to:

Substance Abuse (including alcohol drug abuse)
Mental Health
Psychotherapy Notes
HIV related information (including AIDS related testing)

Purpose of Disclosure:
___ Changing MD's ___ 2nd Opinion
___ Continuing Care ___ Legal
___ At my (patient) request ___ Insurance
___ Workers' Compensation ___ School
___ Other ________________

The confidentially of this record is required under Chapter 899 of the Connecticut General Statues, as well as, Title 42 of the United States code. This material shall not be transmitted to anyone without written consent or authorization as provided in these statutes.

X ______________________________
Signature of Patient or Legal Guardian Date

1. I understand that this authorization will expire one year from my last date of service visit. A photocopy of this form will be considered as valid as the original.
2. I understand that I may revoke this authorization at any time by notifying Kelly Olexik, Privacy Officer, at the address indicated below in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it: Charles P. Gennaula, M.D./Pushpa Kumari, M.D.; 100 Peasant Village Lane; Belle Vernon, PA 15012
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.
4. My health care and payment for my health care will not be affected if I do not sign this form.
5. I understand that my refusal to sign this Authorization will not jeopardize my right to obtain present or future treatment for psychiatric disabilities except where disclosure of the information is necessary for the treatment.
6. I understand that I will get a copy of this form after I sign it.

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

FOR OFFICE USE ONLY

Date Request Filled By Fee Collected