Authorization for Use or Disclosure of Protected Health Information

I authorize my healthcare provider and/or administrative and clinical staff to use or disclose the following protected health information.

NAME AND CONTACT INFORMATION OF ENTITY/PRACTICE OR PERSON AUTHORIZED TO RECEIVE/EXCHANGE INFORMATION PERTAINING TO MY HEALTHCARE.

NAME: _____ PHONE:_____

RELATIONSHIP TO PATIENT:____Emergency Contact ____PCP ____Therapist ____Specialist ____Other

PRACTICE NAME (if applicable):_____

PHONE:_____ EMAIL:_____

DESCRIPTION OF PROTECTED HEALTH INFORMATION I HEARBY AUTHORIZE TO BE USED, REQUESTED, SHARED AND/OR DISCLOSED WITH PERSON AND/OR ENTITY DESIGNATED ABOVE:

_____Initial Assessment **_____Date(s) of Service** **_____Lab Orders/Results**

_____Progress/Chart Notes **_____Medication List** **_____ Emergency Only**

_____Summary of Care **_____Referrals** **_____ Billing/Make Payments**

_____Other (Specify)_____

This document allows Southlake Psychiatry, my provider, and/or administrative and clinical staff to exchange/ release clinical information to the above person/entity for coordination of care between above-named individual/ entity (communication may be exchanged in writing, shared verbally, transmitted/received using any form of electronic transmission or other means necessary to adequately exchange my private health information).

I understand the contents to be released, and that there are statues and regulations protecting confidentiality of authorized information. I acknowledge that the information may contain sensitive material, such as, but not limited to, my condition relating to HIV status, drug or alcohol abuse, and psychiatric or psychological information.

Authorization for Use or Disclosure of Protected Health Information (Continued)

I confirm I understand I have the right to revoke this authorization in writing, at any time by sending written notification to Southlake Psychiatry's privacy officer. I understand this authorization will be valid from the date signed until Southlake Psychiatry's privacy officer receives a revocation letter from myself or my legal guardian/ representative (if applicable). I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand the information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be covered by federal or state law. This does not expire unless revoked by patient.

My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except (1) If my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

The use or disclosure requested under this authorization may result in direct or indirect remuneration to my physician from a third party (if applicable).

PATIENT NAME (PRINT):_____DOB:_____/_____/_____

SIGNATURE OF PATIENT (IF 18 OR OLDER), OR PARENT/LEGAL GUARDIAN/REPRESENTATIVE:

X_____TODAY'S DATE:_____/_____/_____