AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT NAME (please print): _____ **DOB:** _____

I hereby authorize disclosure of my medical information to/from the named individual or organization listed below. Please fully complete the form. **Incomplete forms will be null and void.**

□ ALL HEALTH INFORMATION
□ BILLING INFORMATION
□ OBTAIN MEDICAL RECORDS
□ OTHER _____

Purpose for disclosure: _____

1._____ _____
FULL NAME (OF PERSON OR ENTITY THAT INFORMATION WILL BE RELEASED TO) TELEPHONE

_____ _____
ADDRESS FAX

2._____ _____
FULL NAME (OF PERSON OR ENTITY THAT INFORMATION WILL BE RELEASED TO) TELEPHONE

_____ _____
ADDRESS FAX

3._____ _____
FULL NAME (OF PERSON OR ENTITY THAT INFORMATION WILL BE RELEASED TO) TELEPHONE

_____ _____
ADDRESS FAX

- I understand that specific information to be disclosed may include Drug, Alcohol Abuse or Mental Health Treatment, information regarding communicable diseases including Human Immunodeficiency Virus (HIV), Acquired Immunodeficiency syndrome (AIDS), and other medical conditions, laboratory results, treatment and any other such related information.
- I understand that the information released pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA privacy regulations.
- I authorize that a photocopy of this authorization is acceptable as an original.
- This authorization will remain in effect indefinitely unless revoked in writing. I understand that my treatment is not conditioned upon my providing this authorization. I understand that I have the right to revoke this authorization at any time by providing a written notification to: The Privacy Officer, Apex Psychiatry, 614 B S. Watters Rd., Suite 203, Allen, TX 75013. Apex Psychiatry shall not be deemed responsible for release of any information pursuant to this authorization prior to revocation.
- I understand that there will be a charge for release of photocopies of my medical record. Please indicate below if you need the photocopies of your medical record to be sent to the above named individual or organization.

NAME: _____ RELATIONSHIP TO PATIENT: _____

SIGNATURE: _____ DATE: _____

WITNESS: _____ DATE: _____

PLEASE SEND COPIES OF MY MEDICAL RECORD TO THE ABOVE NAMED INDIVIDUAL OR ORGANIZATION.

□ Entire Medical Record
□ Psychiatric Evaluation
□ Other (Please Specify) _____

A charge of $25.00 for the first 20 pages and $0.50 per additional page applies for copying.