Family Psychiatry Center
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Phone (916) 647-4044, Fax (916) 647- 4290
www.FamilyPsychiatryCenter.Com, Email: Info@FamilyPsychiatryCenter.Com

Disclosure of Health Information

Patient Information

Patient Name: _____ DOB: _____
Street Address:_____ City_____ State: _____ Zip:_____
Phone Number: (Home) _____ (Mobile)_____

Recipient of Health Information (Please circle all that apply)

I hereby authorize **Family Psychiatry Center, Inc** to: Disclose to Request from
Person/Organization: _____
Street Address:_____ City_____ State: _____ Zip:_____
Phone Number: _____ Fax Number: _____

Purpose of Disclosure (Please circle all that apply)

The purpose of the disclosure of my health information is:

Care coordination Treatment planning Legal Billing/payment activities Personal use

Other *(*specify*):*_____

Information to be Disclosed

I authorize the following information to be disclosed:

All of my health information and records, including, my medical and mental health history, lab results, diagnoses, treatment, prescriptions and psychotherapy notes.

OR

Only the following information (specify)*:*_____

Expiration and Revocation

This Authorization will expire on the date that is five (5) years from the date of my signature below.
I understand that I may revoke this Authorization at any time by notifying Family Psychiatry Center in writing, except to the extent Family Psychiatry Center has already taken action in reliance on this Authorization.

Please Turn Page Over And Fill Out The Other Side.

Expiration and Revocation (Initial all that apply)

I authorize the disclosure of the following **specially protected health information**:

- Inpatient/residential mental health treatment information Initials: _____
- Alcohol/drug treatment records Initials: _____
- Lab test results Initials: _____
- Genetic test results Initials: _____
- SOAP notes **ONLY** Initials: _____

Signature

I have read this form and I understand and agree to its terms. I authorize Family Psychiatry Center to disclose the information identified above.

I understand that Family Psychiatry Center cannot condition my treatment, payment, enrollment or eligibility for benefits on my provision of this Authorization. I understand that information disclosed pursuant to this Authorization, except for alcohol/drug treatment records protected by 42 CFR Part 2, may be subject to redisclosure by the recipient and no longer protected by HIPAA. I understand that I have the right to receive a copy of this Authorization.

_____ _____

Patient Signature Date

If you are signing this Authorization as a legal or personal representative of the patient, please indicate your authority to act on behalf of the patient and sign below.

- Parent
- Guardian
- Conservator
- Health Care Surrogate
- Power of Attorney for Health Care
- Executor/Administrator

_____ _____

Signature Date

_____

Print Name