AJ PSYCHIATRY

***AUTORIZATION FOR DISCLOSURE AND/OR TO RECEIVE PROTECTED HEALTH INFORMATION***

**Name**: _____

**MRN**: _____

**DOB**: _____SSN: _____

I understand I have the right to refuse to sign this authorization. I understand that treatment, benefits, or payment processing will not be withheld if I refuse to sign this authorization

**ACTION REQUESTED**

☐ Disclose Information or Receive Information
Org/Person: _____
Address: _____
City: _____ ST _____ Zip _____

**PURPOSE OF DISCLOSURE**

☐ Personal use
☐ Treatment/Continuing care
☐ Attorney/Legal
☐ Educational use
☐ Discuss with family
☐ Disability
☐ Housing
☐ Other (*specify*) _____

**TYPE OF INFORMATION: (Check all that apply)**

☐ Medical records (From: _____ To: _____)
☐ Diagnosis
☐ Evaluations/Assessment
☐ Treatment plan
☐ Education records
☐ Other (Specify type – discharge summary, billings, diagnosis, etc) _____

☐ ☐ ☐

**EFFECTIVE TIME PERIOD**

This authorization is valid for 1 year from the date it is signed, and will expire on_____, or at any time to revoke and provide such notice to revoke in writing

**RIGHT TO REVOKE**

I may revoke this authorization at any time by giving written notice stating my intent to revoke this authorization to the person/organization who I authorized to release or receive my health information. The revocation will be effective the date it is received by the person or organization that I have withdrawn permission except to the extent the organization has already relied upon my authorization to use or disclose my health information as described in the Notice of Privacy Practices

_____ _____
*Individual Legally Authorized Representative* *Date*

Printed Name of Legally Authorized Representative (if any): _____

Specify relationship to individual: Parent of Minor Guardian Other: _____

**Witness/Staff**: _____ **Signature**: _____
*Print*