Consent for Release of Protected Health Information

I,_____, hereby authorize Élan Psychiatry to disclose information described below to:

Name:_____
Address:_____
Phone:_____
Fax:_____

By the boxes that I approve below, I authorize the release of the following medical information to the person/entity name above.

All information held about me, including medical record and billing record information and all of the items below (even if the boxes are not each checked)

☐ Mental Health Diagnosis
☐ Medication Management Information
☐ HIV/AIDS Related Treatment Information
☐ Mental Health Treatment Information
☐ Substance Abuse Treatment Information
☐ Psychiatric Evaluation
☐ Lab Results
☐ Other (Please specify):_____

The purpose or need for the exchange and disclosure of the information to:

☐ Facilitate Treatment
☐ Summarize Treatment
☐ At My Request
☐ Other (Please state purpose clearly):_____

The information will be transmitted in the following fashion:

☐ Written ☐ Verbal ☐ Electronic

I understand that my records are protected under the Federal Confidentiality Regulations, including but not limited to the Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR Part 2) and the Health Insurance Portability and Accountability Act (HIPPA) and cannot be disclosed without my written consent unless otherwise provided in the regulations. This consent is subject to revocation at any time by notifying the practice in writing except to the extent that the practice has already taken action in reliance on it. If not previously revoked, this consent expires automatically three years from the date of the signature below.

_____ _____

Patient Signature Date Staff Signature Date