PATIENT NAME: _____ BIRTHDATE: _____
PATIENT PHONE NUMBER: _____

I am/have been a patient _____ or I am the patient's authorized representative. I understand that this facility has legally protected health information about me or the person that I represent. I understand that signing this form will not affect the treatment that I receive in any way. This authorization expires 2 years after the dated signed, but I have the right to revoke this release at any time by sending a written request to the facility I have authorized to release the information.

I, _____, hereby authorize_____, to
❑ obtain from and/or ❑ release to:

Name of Facility and /or Individual: _____
Attention: _____ Phone Number: _____
Address: _____
City, State, Zip code: _____

❑ I give permission to fax to number: _____ ATTN: _____
❑ I authorized the release of (please check all that apply): ___ mental health ___drug and alcohol information in any record requested.

Information Authorized For Release:

❑ Psychiatric Evaluation	❑ Psychiatric Medication History	❑ Verbal Communication Only
❑ Psycho-Social Assessment	❑ Medication Check record	❑ Progress Notes
❑ Psychotherapy Notes treatment record	❑ Letter/Report re: summary of treatment	
❑ Treatment attendance record	❑ Report to satisfy specific court ordered request	❑ Other (specify):

Records/Information From (*date*)_____ to (*date*) _____

Purpose of Request: ❑Continuity of Care
❑ Other (specify): _____

I release the above entity that disclosed this information from any legal responsibility or liability for disclosure of the above information to the extent that the information was used for its stated purposes. Information used by or disclosed to other organizations pursuant to this authorization may no longer be protected by our Privacy Rule, but further disclosure by organizations other than _____. requires my additional signed release.

I understand that my records are protected under federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be Disclosed without my written consent unless otherwise provided for in the regulation. I understand that I may revoke this consent verbally or in writing at any time except to the extent that the action has been taken in reliance on it. **This authorization expires two years from date of patient signature, unless otherwise stated.**

Unless I have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including but not limited to, written or electronic format.

Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of this information without written authorization from the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.

Signature _____ Date _____
Signature of Patient, Legal Guardian, or Authorized Representative (14 years of age or older may authorize release of mental health information. A minor can authorize release of drug & alcohol treatment information without parental consent)

Signature_____Date_____
(Witness)

Verbal Authorization _____ _____ _____ _____
Date Witness #1 Date Witness #2

Medical Records to be released to patient Yes ____ No _____ _____ Muhammad Shaikh, MD _____Date