AUTHORIZATION TO OBTAIN, USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: _____

Last First Middle

Home Address: _____

Home Telephone: _____ Date of Birth: _____

I authorize Donna Elam MPAC and the named party below to exchange written and verbal information including my protected health information, including medical treatment, mental health treatment, educational information for the purpose of providing psychiatric assessment, diagnosis, treatment or coordinating care unless specified otherwise below.

Home Address: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____ Fax: _____

INFORMATION COVERED UNDER THIS RELEASE

_____ Entire medical record (Examples include discharge summaries, medical assessments, lab data and information from a primary care physicians office)

_____ Ongoing communication regarding psychiatric or mental health care (Examples include ongoing care with a primary care physician or mental health provider)

_____ Individual Education Plan, school psychological testing, and information relating to the academic performance and behavior of child in a school setting.

_____ Psychological testing

_____ Information for referral purposes

_____ Other (please specify) _____

_____ Specific authorization for information related to testing, diagnosis and treatment for drug or alcohol use.

_____ Specific authorization for information related to testing, diagnosis and treatment of sexually transmitted diseases or HIV

The purpose of this disclosure is:

Medical care ☐ Legal Matter ☐ Insurance ☐ Personal ☐

TERM: Unless otherwise specified this authorization will expire on termination of treatment with Donna Elam if for a minor, the time at which the minor reaches age 13.

This authorization expires:

_____ Termination of treatment with Donna Elam or if a minor reaches age 13. (Default)

_____ 90 days from the date signed

_____ on other date, reason or event (specify) _____

By my signature below, I hereby authorize Donna Elam MPAC, to obtain, use and/or disclose my health information for the term of this Authorization for the specific purposes listed ("At the request of the patient" is sufficient if the patient is initiating this Authorization). I understand that once Donna Elam MPAC disclose my health information to the recipient, Donna Elam cannot guarantee that the recipient will not redisclose my health information to a third party. Any such third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information. I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation, or quality of PA Elam's treatment of me; except, however, if my treatment by PA Elam is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case PA Elam may refuse to treat me if I do not sign this Authorization. I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to Donna Elam. The revocation will be effective immediately upon Donna Elam's receipt of my written notice, except that the revocation will not have any effect on any action

taken by Donna Elam in reliance on this Authorization before it received my written notice of revocation

I have read and understand the terms of this authorization and have had an opportunity to ask questions about obtaining, using and disclosing my health information. By my signature below, I hereby, knowingly and voluntarily authorize Donna Elam to obtain use and/or disclose my health information in the manner described above.

x	x	x
Signature of Patient or Personal Representative	Relation to patient (self, guardian, parent etc)	Date