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Authorization for Disclosure of Mental Healthcare Information

Fill in the appropriate information in each applicable section.

Patient Full Name: ____ Date of Birth:________________

Information to be released by Dr. Gelbart to:

Person/organization name: ____

Phone Number: ____________________________ Fax Number: _______________________________

Address: _________________________________City/State: _____________________ Zip Code: ___________________

Purpose of Disclosure: ____

Items/Information to be released (please check all that apply):

- ☐ Complete Medical Record *(Including mental health, covers all)*
- ☐ History and Physical Report
- ☐ Discharge Summary
- ☐ Psychological Testing
- ☐ Consultation Reports
- ☐ Psychiatric Evaluation
- ☐ Discharge Instructions/Medication Lists
- ☐ Lab Reports
- ☐ Emergency Room Report

Please initial to provide consent to release the following information:

_____ "By initialing here I give my consent to share Information on Sexually-Transmitted disease"

_____ "By initialing here I give my consent to share mental health and Substance Abuse information"

I understand that:

1. I may refuse to sign this authorization and that this is strictly voluntary.
2. If I do not sign this form, the payment for my health care should not be affected.
3. If I do not sign this form, it may affect my treatment plan in terms of what the physician is able/willing to prescribe.
4. I may revoke this authorization at any time in writing, but if I do, it should not have any effect on any actions taken prior to receiving the revocation.
5. If the requestor or receiver is not a health plan or healthcare provider, the released information may no longer be protected by federal privacy regulations and may be disclosed.
6. I may request a copy of this form after I sign it.
7. This form will expire in one year unless otherwise specified on this date: **Expiration Date:** __________________

SIGNATURES

I have read the above information and authorize the disclosure of the protected health information as stated.

Signature of Patient/Guardian/Patient Representative: ____

If signed by person other than patient: indicate relationship and authority to do so (Relationship): _________________________

Print Name of Patient or Patient Representative: ____

Date: _______________________ **Time:** ___________________