STONE CREEK PSYCHIATRY
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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

PATIENT NAME:_____ BIRTHDATE:_____

ADDRESS:_____ CITY_____ STATE_____ ZIP_____

PHONE NUMBER: (Home)_____ (Work)_____ (Other)_____

1. Please release my records/communications

FROM: ____Stone Creek Psychiatry: (listed above)
____Clinic, Organization/Person:_____

Address:_____ City:_____ State:____ Zip:_____

Phone:_____ Fax:_____

2. Or Check ___**EXCHANGE WITH**

TO: ____Stone Creek Psychiatry: (listed above)
____Clinic, Organization or Person:_____

Address:_____ City:_____ State:_____ Zip:_____

Phone:_____ Fax:_____

3. Information to be released: ___Any and all pertinent records (including all items below) OR check all that apply

___Discharge summary/note
___History & Physical exam
___Consultation reports
___Progress/clinic notes
___Case manager reports
___Psychological tests/summaries
___Lab reports
___Pathology reports
___Operative reports
___Emergency records
___Rehab records (pt/ot)
___Other_____
___Mental Health records
___Chemical Dependency/Substance Abuse records
___AIDS/HIV records
___Genetic conditions record
___Medication records
___ Provider form
___ FMLA paperwork

ALL DATES:_____ SPECIFIC DATES:_____

4. I am requesting this information /authorization be released for the following purpose(s):

____Transfer of care with another provider
____Coordination of care
____Insurance claim/application purposes
____Social Security Appeal
____Litigation/Legal/Attorney review
____Personal use
____Social Security Disability Determination
____Other_____
____Verbal communication
____Billing purposes
____Work related

I understand the following:
I may revoke this authorization at any time by writing to the address listed at the top of this form. I understand that the revocation will not apply to information that has already been released in response to this authorization.

This authorization will automatically expire one year from the date of my signature or at the date I specified here_____. I understand that once information is released pursuant to this authorization Stone Creek Psychiatry cannot prevent the re-disclosure of this information to another third party.

A signed copy of this form is considered valid if it has not been altered. Your signature indicates that you have read and understand this form and authorize release of your information as described above.

_____ DATE:_____
Signature of Patient/Authorized Person

_____ DATE:_____
Authorized Person's Authority to Sign
REASON PATIENT IS UNABLE TO SIGN:_____MINOR_____DECEASED_____OTHER_____