www.juliedbrunopsyd.com

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

"Protected Health Information"("PHI") means any information which 1) identifies you; 2) is created or received by IBH or a member of our professional staff; and 3) is i) related to your mental or physical health or condition; ii) the diagnosis or treatment of your mental or physical health or condition; or iii) past, present, or future payment for providing health care to you. This form authorizes IBH to disclose or receive Protected Health Information (PHI) in the manner, to the persons, and under the circumstances that you authorize.

Patient Name: _____ DOB: _____

I hereby authorize Infinite Behavioral Health Inc (IBH) to release to or obtain from the following health care provider or other person the specific Protected Health Information that I have indicated below. IBH may release or obtain my Protected Health Information in either written or verbal form.

IBH may release my PHI to:

Name: _____
Agency: _____
Address: _____
Address: _____
Phone: _____

IBH may obtain my PHI from:

Name: _____
Agency: _____
Address: _____
Address: _____
Phone: _____

Specific Information to be released:

[ ] Discharge Summary
[ ] Psychiatric Admission Assessment
[ ] Treatment Plan
[ ] History of Drug/Alcohol Abuse
[ ] History/Physical
[ ] Lab/X-ray results
[ ] HIV test results
[ ] Medication Reconciliation
[ ] Psychosocial Assessment
[ ] Psychological Testing
[ ] Educational Assessments
[ ] _____

Purpose for release of information:

[ ] Diagnostic Assessment [ ] Psychiatric or Medical Treatment [ ] Reimbursement by Insurance
[ ] Coordination of my treatment, discharge and aftercare planning [ ] Educational/Vocational/Social Services
[ ] Legal [ ] Other _____

I understand and agree that 1) I have a right to inspect my Protected Health Information; 2) I may revoke this authorization in writing at any time; 3) this authorization will expire three-hundred sixty-five (365) days from the date written below; and 4) Florida State Law prohibits re-disclosure of Protected Mental Health Information by the recipient without my consent. I understand that IBH may disclose my Protected Health Information without my consent only in specific circumstances authorized by law.

I understand that my treating physician may refuse to disclose or allow my inspection of part or all of my PHI if he/she believes that it is necessary to protect me or someone else from psychological or other harm. If this occurs, my physician will notify me in writing regarding his/her decision. If I disagree with the decision, I may appeal the decision through the process explained in the Patient Bill of Rights which I have received.

Signature of Patient:_____ Date :_____

Signature of Parent or Guardian: _____ Date:_____

The signature of **both** the parent/legal guardian **and** the patient is required by law for any patient 14 through 17 years of age.

Signature of Witness_____ Date:_____

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