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RELEASE OF INFORMATION

This form, when completed and signed by you, permits me to release or request protected health information (PHI) from your clinical record to a person/entity you designate.

Name of Patient:_____ Date of Birth:_____

I authorize Dr. Martin (Check all that apply)

( ) To disclose information   ( ) To Receive information   ( ) To Speak with

Name and address of person to whom PHI will be released or requested from:
_____
_____
_____

Regarding the following information:

( ) No restrictions – Dr. Martin may release or request whatever information he feels clinically appropriate
( ) Case History   ( ) Current Medical or psychiatric info
( ) Medications   ( ) Psychological Evaluations
( ) Substance Use   ( ) Other_____

I am requesting this release of information for the following reasons:

( ) To help with my diagnosis and treatment
( ) Other:_____

You have the right to revoke this authorization, in writing, at any time by sending such written notification to the above address. However, your revocation will not be effective to the extent that I have taken action in reliance on this authorization, or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has legal right to contest claim.

I understand that Dr. Martin generally may not condition services upon my signing an authorization to release information unless the psychiatric services are provided to me for the purpose of creating health information for a third party.

I understand that once Dr. Martin has released my PHI under this authorization, the recipient may release that information to other parties and that redisclosure may not be protected by the HIPAA Privacy Rule.

Your privacy is extremely important to me. When I absolutely must talk to a third party about your care, I will disclose the absolute minimum information necessary to complete my task.

_____
Signature of Patient or Responsible Party   Date