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Authorization for Disclosure of Protected Health Information

1. I authorize River City Psychiatry, PLLC and its staff to make the authorized use and/or disclosure of my protected health information.

2. This data shall include (circle all appropriate):

Admission History and Physical	Psychiatric Evaluation	Psychological Testing
Discharge Summary	Progress Notes	Physical examination
Laboratory testing	Diagnosis	Previous treatment(s)
Other________________________		from ____________ to _____________

3. I authorize the following persons (or class of persons) to receive my protected health information:
____
____

4. I understand that I have a right to revoke this authorization at any time. My revocation must be in writing in a letter. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization. I understand that any use or disclosure made prior to the revocation of this authorization will not be affected by the revocation.

5. This consent will expire automatically after 365 days from the date on which it is signed.

6. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment from my psychiatrist or River City Psychiatry, nor will it affect my eligibility for benefits.

7. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable state laws may protect such information.

8. My protected health information will be used or disclosed upon request for the following purposes (please name and explain each purpose): ____

9. I understand that I have a right to inspect and copy my own protected health information to be used or disclosed (in accordance with the requirements of the federal privacy protection regulations found under 45 C.F.R. §164.524).

10. I hereby authorize photocopies and electronic copies of this form to be as valid as the original.

11. This authorization and request is fully understood and is made voluntarily on my part.

Signature	Date
Name	Date of Birth
Name of Personal Representative or Legal Guardian	Relationship to Patient