Valueris Psychiatric Services

Authorization For Release of Confidential Information

PATIENT

Name: _____ Date of Birth ____/____/_____

Address: _____ APT#: _____

City: _____ State: _____ Zip Code:_____

I understand that this authorization is voluntary. I understand that my health information may be protected by the Federal Rules for Privacy of Individually Identifiable Health Information and/or state laws. The only circumstance when refusal to sign means you will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure. I understand that my health information may be subject to re-disclosure by the recipient and that if the organization or person authorized to receive the information is not a health plan or health care provider the information may no longer be protected by state or federal privacy regulations.

AUTHORIZED INFORMATION

I authorize Valueris Psychiatric Services to receive and disclose the following information to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services with the below indicated person(s) or organization(s):

☐ All Records and Reports and Mutual Exchange of All Information

☐ Medical History and Treatment ☐ Laboratory Test Reports

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information may be disclosed if I place my ***initials*** in the applicable space next to the type of information.

_____ HIV/AIDS information _____ Genetic testing information

_____ Mental health information _____ Drug/alcohol diagnosis, treatment, or referral information

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RELEASE TO / FROM

Name: _____ Phone:_____

Address: _____ Fax:_____

City: _____ State: _____ Zip Code:_____

____/____/_____ _____

Date **Signature of Patient or Patient's Legal Representative**

_____

Printed name of Patient or Patient's Legal Representative

You may revoke this authorization in writing at any time. Unless revoked, authorization will automatically expire with conclusion of care.