Valueris Psychiatric Services

Authorization for Release of Confidential Information

Patient

Name:_____ Date of birth: ____/____/_____

Address:_____ 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 Individual 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 organizations(s): Please check all that apply

☐ All records and reports and mutual exchange of all information ☐ Emergency contact only

☐ Appointments only ☐ Financial information only ☐ Medical history and treatment ☐ Lab orders/results

*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

Release To/From

Facility and/or Name:_____

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

Phone: _____ Fax: _____ Email: _____

Did this person refer you to Valueris Psychiatric Services? ___Yes ___ No

Date: ____/____/_____ _____ _____

Signature of Patient Printed name of Patient

Date: ____/____/_____ _____ _____

Signature of Patient's Legal Guardian/Representative Printed name of Patient's Legal Guardian/Representative

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