OPTIMUM Psychiatric Health

142 Lowell Rd., #17-151 Hudson, NH 03051

P: (978) 233-1594 F: (949) 561-4522

Authorization For Use or Disclosure of Protected Health Information (PHI)

COMPLETE ALL SECTIONS, DATE, AND SIGN

I. I, _____ hereby voluntarily authorize the disclosure of information from my health record.
(Name of Patient)

,

II. The information is to be disclosed by: **And is to be provided to:**

NAME OF FACILITY NAME OF PERSON/ORGANIZATION/FACILITY

ADDRESS ADDRESS

CITY/STATE CITY/STATE

III. The purpose or need for this disclosure is:

☐ Further Medical Care ☐ Personal Use ☐ Attorney ☐ Insurance ☐ School ☐ Disability

☐ Research ☐ Other (Specify)

IV. The information to be disclosed from my health record: (check appropriate box(es))

☐ Entire Record ☐ Only the period of events from _____ to _____

☐ Only information related to (specify) _____

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

☐ Alcohol/Drug Abuse Treatment/Referral ☐ HIV/AIDS-related Tests/Treatment ☐ Sexually Transmitted Diseases

☐ Mental Health (Other than Psychotherapy Notes) ☐ Psychotherapy Notes ONLY (by checking this box, I am waiving any psychotherapist-patient privilege)

V. I understand that I may revoke this authorization in writing submitted at any time to Optimum Psychiatric Health, except to the extent that action has been taken in reliance on this authorization. If this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, other law may provide the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate six (6) months from the date of my signature unless a different expiration date or expiration event is stated. For Health Information Exchange authorizations, it is recommended to expire in at least five years.

(Specify new date): _____

I understand that Optimum Psychiatric Health will not condition treatment or eligibility for care on my providing this authorization except if such care is: 1) research related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party. I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164] , and the Privacy Act of 1974 [5 USC 552a].

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE (State relationship to patient) DATE

Effective date of this form is 10/22/2020