Regional Psychiatry
9100 Conroy Windermere Rd, Suite 269, Windermere FL, 34786
Tel: 407-462-1254 / Fax: 407-604-6614

PATIENT NAME:

_____

Last First Middle

Home address: _____City: _____

Home telephone: _____ Date of Birth: _____

I authorize my provider Dr._____ and the named party below to exchange written and verbal information including my protected health information, including medical treatment, mental health treatment, educational information for the purpose of providing psychiatric assessment, diagnosis, treatment or coordinating care unless specified otherwise below.

Name/Facility:

_____

Address:

_____

State:_____
Zip:_____Phone:_____Fax:_____

INFORMATION COVERED UNDER THIS RELEASE

____ Entire medical record (Examples include discharge summaries, medical assessments, lab data and information from a primary care physicians office)
____ Ongoing communication regarding psychiatric or mental health care (Examples include ongoing care with a primary care physician or mental health provider)
____ Individual Education Plan, school psychological testing, and information relating to the academic performance and behavior of child in a school setting.
____ Psychological testing
____ Information for referral purposes

____ Other (please specify)_____

__ ____ Specific authorization for information related to testing, diagnosis and treatment for drug or alcohol use.

____ Specific authorization for information related to testing, diagnosis and treatment of sexually transmitted diseases or HIV

The purpose of this disclosure is: Medical care_____ Legal Matter_____ Insurance_____ Personal:_____

TERM: Unless otherwise specified this authorization will expire on termination of treatment with Dr Pleener . This authorization expires:

_____ Termination of treatment with Dr Pleener

_____ 90 days from the date signed

_____ on other date, reason or event (specify)

_____

By my signature below, I hereby authorize my Regional Psychiatry Provider as written above to obtain, use and/or disclose my health information for the term of this Authorization for the specific purposes listed ("At the request of the patient" is sufficient if the patient is initiating this Authorization). I understand that once my provider discloses my health information to the recipient, my provider cannot guarantee that the recipient will not re-disclose my health information to a third party. Any such third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information. I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation, or quality of my providers treatment of me; except, however, if my treatment with my provider is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case my provider may refuse to treat me if I do not sign this Authorization. I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to my provider. The revocation will be effective immediately upon my providers receipt of my written notice, except that the revocation will not have any effect on any action taken by my provider in reliance on this Authorization before it received my written notice of revocation. I have read and understand the terms of this authorization and have had an opportunity to ask questions about obtaining, using and disclosing my health information. By my signature below, I hereby, knowingly and voluntarily authorize my provider as written above to obtain use and/or disclose my health information in the manner described

X_____X_____X_____

Signature of Patient or Personal Representative Relation to patient (self, guardian, parent etc) Date