AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT'S NAME: _____

SOCIAL SECURITY #: _____ DATE OF BIRTH: _____

I hereby authorize Concord Psychiatry, LLC (DBA Emerald Psychiatry & TMS Center) to have my Protected Health Information:

☐ Released to ☐ Obtained from ☐ Discussed with

DOCTOR/FACILITY/BUSINESS NAME: _____

Address: _____

Phone: _____ Fax: _____

The purpose of this authorization is for _____

-I understand that I may be charged reasonable cost-based fees as allowed by law, for all postage and copying costs and other agreed-upon special services.

-I understand that information disclosed pursuant to this authorization may be redisclosed and may no longer be protected by the federal privacy requirements, including HIPAA, 45 C.F.R., part 164.

-This authorization permits the release of information which may be related to a sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV), behavioral or mental health services and/or treatment for alcohol and/or drug abuse.

-I understand that I have the right to revoke this authorization at any time by sending a written revocation to Concord Psychiatry, but that this authorization cannot be revoked to the extent that protected health information has been previously provided in reliance on this document.

-Concord Psychiatry may not condition treatment, payment, enrollment, or eligibility for benefits if I refuse to sign this authorization.

-A copy of this authorization may be used as an original. This authorization may remain valid for a maximum period of one year following the signature date.

-I have a right to receive a copy of this authorization.

Date: _____ _____

Signature of Patient or Legal Representative

_____

If Representative, Legal Relationship to Patient