# AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT'S NAME: _____ 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/PERSON: _____

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.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I 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

*Emerald Psychiatry & TMS Center*
*495 Metro Place South, Suite 160*
*Dublin, OH 43017*

*Phone: 614-580-6917*
*Fax: 614-368-1357*