**Authorization for Release of Information**

PATIENT’S NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B.\_\_\_\_\_\_\_\_\_\_\_\_\_

I hereby authorize Hanover Psychiatry to share and/or obtain my health information, in verbal, written and/or any other form as required for the purpose of the disclosure as described below, to/from:

Name(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Facility: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_

Tel: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My health information to be shared includes:

* All health information pertaining to my medical history, including mental health treatment records
* Only the following mental health treatment records or types of health information (including any

dates): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I specifically authorize the release of drug and alcohol abuse treatment records (initial if applicable): \_\_\_

Purpose of disclosure: 🞎 Treatment Planning/Coordination of Care

🞎 Other (specify):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that this authorization will expire one year from the date of my signature unless otherwise specified here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(expiration event/date). I understand that I may revoke this authorization at any time by providing written notice to the address above; however, the revocation will not apply to the extent that Hanover Psychiatry has already taken action in reliance on my authorization.

I understand that information disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by federal privacy regulations.

I understand that I am not required to sign this authorization and that my refusal to sign this authorization will not affect my ability to obtain treatment at Hanover Psychiatry nor my obligation to pay for my treatment at the time services are rendered.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient or Personal Representative Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Printed Name of Personal Representative Description of Personal Representative’s Authority