



S Baez, M.D.

www.sbaezmd.com

Tel. (954) 381-4737 Fax (888) 425-5869

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Psychiatric Consultants, Inc., S. Baez, M.D. to release copies of the following confidential information to:

Organization: _____

Name of Person to release documentation: _____ Relationship: _____

Method of Release: (Select one or multiple)

- Email Address: _____
- Mail (Address) _____ State: _____ Zip Code: _____
- Fax: _____
- Entire Contents of Chart
- Psychiatric Evaluation
- Psychiatric Summary
- Most Recent Labs
- Only Pertinent Information in case of emergency
- Copies and/or copies of clinical discussion as needed for treatment
- Consultation Report
- Toxicological Reports/Drug Screen

Other: _____

Purpose

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. In the case of an emergency the reason for the release is to provide emergency care or obtain information in the case of an emergency. If other purpose, please specify _____.

Expiration

Unless sooner revoked, this consent is valid for 120 days from the date of signature due to the need for ongoing communication for the coordination of treatment.

Conditions

I understand that Psychiatric Consultants, Inc., S. Baez, M.D. will not condition my treatment on whether I give authorization for the requested disclosure. The consequences of refusing to sign this authorization have been explained to me.

Form of Disclosure:

Unless you have requested in writing that disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner we deem to be appropriate and consistent with applicable law, including but not limited to verbally, in paper format, or electronically.

RE-DISCLOSURE

"This information has been disclosed to you from records protected by Federal Confidentiality rules (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse Client"

I may request a copy of this authorization for my records.

I understand that my records are protected under Federal Confidentiality regulations (42 CFR Part 2). Published August 10, 1987. and the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191), 42 U.S.C. Section 1320d, et. Seq, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand that my medical record may contain information concerning my psychiatric, psychological, drug and alcohol abuse, HIV/Acquired Immune Deficiency Syndrome (AIDS) and/or related conditions. (Under the Mental Health Code, release of mental health records must be germane to the purpose and need for disclosure).

_____ SIGNATURE OF PATIENT

DATE: _____

RIGHT TO REVOCATION

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Horizon Behavioral Center, P.A. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

I _____ HEREBY REVOKE THIS RELEASE OF INFORMATION.

DATE: _____