S Baez, MD
www.sbaezmd.com
Tel. (954) 381-4737 Fax (888) 425-5869

AUTHORIZATION TO REQUEST INFORMATION

I hereby authorize Psychiatric Consultants, Inc/ S Baez, MD to request copies of the following confidential information to:

Organization: ____

Name of Person to receive documentation: ____________________________________Relationship: ________________

Method of Request: (Select one or multiple)

☐ Email Address: ____

☐ Fax: ____

__Entire Contents of Chart
__Medical History & Physical Exam
__Psychiatric Evaluation
__Psychiatric Summary
__Presence in Treatment
__Progress in Treatment
__Nursing/Medical Assessment
__Most Recent Labs/Medication Log
__Only Pertinent Information in case of emergency
__Copies and/or copies of clinical discussion as needed for treatment

__Discharge/Transfer Summary
__Assessments
__Consultation Reports
__Cooperation/Motivation
__Financial Information
__Prognosis
__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, MD 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 in 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 Heath 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 CLIENT 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: ________________