MILE HIGH PSYCHIATRY

HIPAA Privacy Release of Information Authorization Form

Patient Name: _____ Patient DOB: _____

1. I hereby authorize all medical service sources and health care providers at Mile High Psychiatry to use and/or disclose the protected health information (PHI) described below to my agent identified in my durable power of attorney for health care named _____. (If there is no power of attorney designated, leave blank)

2. Authorization for release of PHI covering the period of Health Care (check one)

A. ❑ From (date) _____ to (date) _____

B. ❑ All past, present and future periods

3. I hereby authorize the release of PHI as follows, (check one)

A. ❑ My complete health record (including records relating to Mental health care, communicable diseases, HIV or AIDS and treatment of alcohol/drug abuse)

B. ❑ My complete health record with the exception of the following Information: (check all that apply)

____ Mental Health Records

____ Communicable Diseases (including HIV or AIDS)

____ Alcohol/Drug abuse

____ Lab Results

____ Other (please specify) _____

4. I authorize disclosure of information regarding my billing, condition, treatment and prognosis along with my PHI as described in paragraph 3A and 3B to the following individuals:

Name: _____ Phone: _____-_____-_____ Relationship:_____

Name: _____ Phone: _____-_____-_____ Relationship:_____

Name: _____ Phone: _____-_____-_____ Relationship:_____

5. This medical information may be used by the person(s) I authorize to receive this information for medical treatment, consultation, billing or claims payment and for other purposes that I may direct

6. I understand that I have the right to revoke this authorization in writing at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization, or if my authorization was obtained as a condition of obtaining insurance

coverage and the insurer has a legal right to contest a claim

7. I understand that my treatment, payment, enrollment, or eligibility benefits will not be conditioned on whether I sign this authorization

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by the federal or state law

Patient Signature: _____ Date:_____