

## Authorization to Disclose Protected Health Information

I \_\_\_\_\_ authorize **HopeFirst Psychiatry PLLC** to  
\_\_\_ Obtain From and/or \_\_\_ Release to  
**Person or Facility and Relationship to Patient (not patient's name unless releasing to self)** \_\_\_\_\_

Email: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Time Frame (*release does not expire unless revoked or specified*) : \_\_\_\_\_

I hereby acknowledge that I fully understand the above statements as they apply to me and that my records cannot be disclosed without my written consent except as otherwise specifically provided by law. I understand that by law, I need not consent to the release of this information, but I choose to do so voluntarily.

### Please release the following:

\_\_\_ Entire Record    \_\_\_ Progress Notes    \_\_\_ Treatment Plans    \_\_\_ Physical Exam  
\_\_\_ Notice of Admission    \_\_\_ Lab Reports    \_\_\_ Med Notes    \_\_\_ Summary    \_\_\_ Consults  
\_\_\_ Psychological Tests    \_\_\_ Other, please specify: \_\_\_\_\_

**This information is needed for:** \_\_\_ Ongoing Treatment    \_\_\_ Aftercare    \_\_\_ Referral

\_\_\_ Other, please specify: \_\_\_\_\_

**Limitations on disclosure (if any):** \_\_\_\_\_

### The information to be disclosed may include confidential information as initialed below:

\_\_\_ Psychiatric Evaluation/Treatment    \_\_\_ HIV Test Results  
\_\_\_ Venereal Disease/STI/STD    \_\_\_ Alcohol/Drug Use (past or present)\*

\*NOTE: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations (42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

I further release **HopeFirst** **Psychiatry PLLC** from all legal responsibility or liability that may arise from this disclosure, and I understand that I may revoke my consent at any time, unless action on this release has already begun in good faith.

**Signature:** \_\_\_\_\_

**Printed Name of Person signing form:** \_\_\_\_\_

**Relationship to patient:** \_\_\_\_\_

**Date:** \_\_\_\_\_