Patient Name: ___________________________________
Date of Birth: ___________________________________

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

AUTHORIZATION

I voluntarily authorize and direct the Adelpha Psychiatric Group to disclose/receive my protected health information to the entity/entities identified below:

Name (individual/organization):	Address:	Phone/Fax:
Name (individual/organization):	Address:	Phone/Fax:
Name (individual/organization):	Address:	Phone/Fax:
Name (individual/organization):	Address:	Phone/Fax:

(strike out unneeded boxes above)

EFFECTIVE PERIOD

This authorization for release of information covers the period of healthcare from:

[ ] _____/_____/__________ to _____/_____/__________

--- or ---

[ ] all past, present, and future periods.

EXTENT OF AUTHORIZATION

[ ] I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

--- or ---

[ ] I authorize the release of my complete health record with the exception of the following information:

[ ] Mental health records
[ ] Communicable disease (including HIV and AIDS)
[ ] Alcohol/drug abuse treatment
[ ] Other (*please specify*): ____

(Continued on next page)

Patient Name: ______________________________
Date of Birth: ______________________________

PURPOSE

This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

EFFECTIVE TERM

This authorization shall be in force and effect until one year from the date signed below.

REVOCATION

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that 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.

REDISCLOSURE

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

PHOTOCOPY

A photocopy, fax or electronic copy of this authorization shall be considered as effective as and as valid as the original.

______________________________________ ______________________
Signature of patient or personal representative Date

____
Printed name of patient or personal representative and his/her relationship to patient