Authorization for Uses/Disclosures of Protected Medical Information

Patient Name:_____ Date of Birth:_____

I request and authorize

Lake Mary Psychiatry and Counseling, LLC
305 Waymont Court, Suite 111
Lake Mary, FL 32746
Phone: (407)324-0405, Fax: (407)324-0075

to release my information to ☐ and/or obtain my information from ☐ the following person or agency (check one or both boxes):

Description of information to be used or disclosed (check where applicable):

( ) Psychiatric Evaluations, Diagnosis, and Progress Notes

( ) Psychological Evaluation and Psychotherapy Notes

( ) Medical Records

( ) Demographic, Financial, and Insurance Information

( ) Form or letter

( ) The persons listed below may communicate verbally regarding my evaluation and treatment

Purpose for the use of disclosure:

This authorization (check where applicable):

( ) May ( ) May not include information related to HIV/AIDS
( ) May ( ) May not include information related to mental health
( ) May ( ) May not include information related to substance abuse

This authorization (check where applicable):

( ) Expires on _____/ _____/ _____
( ) Expires upon the occurrence of (describe the expiration event):

This authorization is made in compliance with state and federal law pertaining to the disclosure of medical, HIV, mental health, and substance information. It is also in compliance with 42 CFR Part 2 (Public Law 93-282) which prohibits further disclosure without the express written consent of the person to whom it pertains, or as otherwise permitted by such regulations. **You have the right to revoke this authorization. Your revocation must be in writing and addressed to: Office Manager, Lake Mary Psychiatry and Counseling, LLC, 305 Waymont Court, Suite 111, Lake Mary, FL 32746**. We will not condition the provision of health care services on whether you sign this authorization. The information used or disclosed pursuant to this authorization may be re-disclosed by the recipient of the information and may no longer be protected by applicable law or regulation. You have a right to a copy of this signed authorization if the authorization is being made at our request.

Signature of Patient:_____ Date:_____
Witness:_____ Date:_____

If the patient is unable to sign, complete the following:

Representative's name:_____ Date:_____

Relation to patient: _____