Richardson
Psychiatric Associates

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I (Full Name of Patient) _____ D.O.B. _____ , authorize

Richardson Psychiatric Associates • 11 Shenango Road, Suite 1 • New Castle, PA 16105 • Phone: 724-657-1881 • Fax: 724-657-9178

TO: RELEASE TO ❑ RECEIVE FROM ❑ EXCHANGE WITH ❑

Name of Agency/Individual _____

Address _____

City/State/Zip _____

The following information for the years _____ (Check all that apply)

____ Circumstances of Referral	____ History of contacts	____ Immunization record
____ Assessment / diagnosis	____ Discharge summary	____ Educational records
____ Family composition & history	____ Psychiatric assessment	____ Other _____
____ Psychological test results	____ Medications past / present	____ Other _____
____ Treatment plan	____ Physical exam & medical history	____ Other _____
____ Service notes	____ Lab test results	____ Other _____

The purpose of the disclosure is to: _____

I understand that:

1. This authorization extends to all or any part of the records/information designated above which may include diagnosis and/or treatment for physical and mental illness, alcohol/drug abuse, HIV/AIDS, and may include health information from sources other than Richardson Psychiatric Associates.
2. The information disclosed is protected by law and may not be re-disclosed without my written authorization or as otherwise authorized by law; however, if the person or entity who receives the information is not a health care provider or health plan covered by the federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations.
3. If no previously revoked, this authorization will expire upon _____ (date, event or condition). If no date, event or condition is specified then this consent will automatically expire 180 days from the date of signing.
4. I may revoke this authorization at any time by providing written notice to the disclosing agency/individual named above as described in the Notice of Privacy Practices, except:
    a. In the case where action has already been taken; or
    b. This authorization is obtained as a condition for obtaining insurance reimbursement.
5. The person or entity making the disclosure cannot control the recipient's use of the information.
6. I may review the information to be released by contacting the releasing agency/individual named above.
7. This authorization is voluntary and I may refuse to sign this authorization. Unless allowed by law, my refusal to sign this authorization will not affect my ability to obtain treatment, payment, enrollment, or eligibility for benefits.

I certify that I am (Check appropriate box):

❑ The patient, and the identification that I have provided is true and correct.
❑ The patient's authorized representative, and that the identification and proof of authority that I have provided are true and correct.

My relationship to the patient is that of: _____

_____ Patient's Signature / Date

_____ Parent/Guardian/Authorized Representative's Signature / Date

_____ Richardson Psychiatric Associates Staff Member's Signature / Date

_____ Printed Name of Richardson Psychiatric Associates Staff Member

Name _____