Mind Over Matter Psychiatry

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Authorization To Obtain Mental Health Treatment Information

I, ________________________________ whose Date of Birth is ___________, authorize Mind Over Matter Psychiatry to obtain records from:

Organization: ____

Individual: ____

Description of Information to be obtained (Patient/Client should initial each item to be disclosed)

_____ Assessment
_____ Diagnosis
_____ Psychosocial Evaluation
_____ Psychological Evaluation
_____ Psychiatric Evaluation
_____ Treatment Plan or Summary
_____ Current Treatment Update
_____ Medication Management Information
_____ Presence/Participation in Treatment
______Nursing/Medical Information

PURPOSE

_____ Educational Information
_____ Discharge/Transfer Summary
_____ Continuing Care Plan
_____ Progress in Treatment
_____ Demographic Information

_____Psychotherapy Notes (Cannot be combined with any other disclosure)
______Other________________________

This information may be used or disclosed in connection with mental health treatment, payment, or healthcare operations.

REVOCATION

I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Mind Over Matter Psychiatry at drs@dnppsych.org. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

EXPIRATION

Unless sooner revoked, this authorization will expire following the termination of the therapeutic relationship, or as otherwise indicated:

CONDITIONS

I further understand that Mind Over Matter Psychiatry will not condition my treatment on whether I give authorization for the requested disclosure. However, it has been explained to me that failure to sign this authorization may limit the quality of care I receive.

FORM OF DISCLOSURE

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

REDISCLOSURE

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a state law applies that is more exact than HIPAA and provides additional privacy protections.

I will be given a copy of this authorization for my records upon request.

Signature of Patient/Client **Date**

____

Signature of Parent, Guardian, or Representative **Date**

____

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.).

____

_____Check here if patient/client refuses to sign authorization