Mind Over Matter Psychiatry

Roxanne Singer-Gheorghiu, DNP
P:(646)-397-6063

HIPAA Authorization Form

I ____

hereby authorize the use or disclosure of my protected health information as described below:

1) AUTHORIZED PERSONS TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Mind Over Matter Psychiatry is authorized to disclose the following protected health information to:

____

____

2) DESCRIPTION OF INFORMATION TO BE DISCLOSED

The health information that may be disclosed is:

- All past, present, and future periods of health care information

3) PURPOSE OF THE USE OR DISCLOSURE

- The purpose of this use or disclosure is continuity of care

4) VALIDITY OF AUTHORIZATION

This authorization form is valid beginning on _______________________________________
and expires upon termination of therapeutic relationship between client and Mind Over Matter Psychiatry (unless revoked by client on an earlier date).

5) ACKNOWLEDGEMENT

I understand that the information used or disclosed under this authorization form may be subject to re-disclosure by the person(s) or facility receiving it and would then no longer be protected by federal privacy regulations.

I have the right to refuse to sign this authorization form. If signed, I have the right to revoke this authorization, in writing, at any time. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

Patient Signature:

Guardian Signature/Responsible Party:

Date: