# AUTHORIZATION FOR THE REQUEST OF PROTECTED HEALTH INFORMATION

This completed form authorizes Alabama Psychiatry Services, P. C. to request the following patient information:

Patients' Name: _____ DOB: _____ SS #: _____

I, the undersigned, authorize _____ at Alabama Psychiatry and Counseling to request the following specific patient information: (check those that apply)

- ☐ Progress notes, Inclusive dates: _____ to _____
- ☐ Copy of outpatient initial assessment
- ☐ Outpatient treatment plan
- ☐ Summary of outpatient treatment to date
- ☐ Summary of psychological evaluation
- ☐ Copy of inpatient H&P
- ☐ Copy of inpatient discharge summary
- ☐ Coy of lab work related to _____
- ☐ IOP intake evaluation
- ☐ IOP treatment plan
- ☐ IOP summary of treatment to date
- ☐ IOP discharge plan
- ☐ CD program initial assessment
- ☐ CD program treatment plan
- ☐ CD program discharge summary
- ☐ CD program summary of treatment to date
- ☐ Other: (describe) _____

_____

_____

This information is to be requested from: (specific name and address)

_____

_____

_____

This information is to be used for the specific purpose(s) of:

_____

_____

_____

_____

This authorization is valid for the period of one year from the date listed below. The patient signature listed below may revoke the authorization at any time and may refuse to sign the authorization. Upon signature, the patient will be provided a copy of this authorization. The information disclosed pursuant to this authorization will not be subject to redisclosure by the recipient and will be covered by the federal Privacy Rules. The patients' eligibility for benefits, condition of treatment, payment or enrollment to any health plan will not be affected by this authorization. This authorization conforms to 45 CFR – Parts 160 and 164, Dec. 28, 2000.

_____ _____ Date: _____
Patient Signature Patient Name

_____ _____ Date: _____
Parent/Patient Representative Signature Printed Name and Relationship to Patient

_____ _____ Date: _____
Witness Signature Witness Name