

Authorization to Release Information to Physician/Psychiatrist

Patient Name:		Date of Birth:	
I hereby authorize Cognitive Health Solutions, LLC to:		<input type="checkbox"/> Release to	<input type="checkbox"/> Obtain from
Person or Facility:			
Person or Facility Phone #:		Person or Facility Fax #:	
Person or Facility Address:			
<input type="checkbox"/> I DECLINE CHS to obtain/ release information with my PCP for the continuity of my care.			
<input type="checkbox"/> I ALLOW CHS to obtain/release information with my PCP for continuity of my care (specifications below)			
<input type="checkbox"/>	All available information and records (all of the information listed below, including, but not limited to, mental health and substance abuse information) may be release to and received from the practice listed above		
<input type="checkbox"/>	Psychological/Psychiatric evaluation, diagnosis, treatment, and recommendation information	<input type="checkbox"/>	Contact, scheduling, & demographic information
<input type="checkbox"/>	Laboratory tests with imaging results (ex. X-Ray, MRI)	<input type="checkbox"/>	Professional observation, opinion, and impression
<input type="checkbox"/>	Intake, family/social history, and treatment history	<input type="checkbox"/>	Medication history, prescriptions, medical diagnosis, medical treatment
<input type="checkbox"/>	Substance abuse assessment and treatment information	<input type="checkbox"/>	Achievement/Educational Records
<input type="checkbox"/>	Legal history/involvement with the court system		
<input type="checkbox"/>	Other (specify):		
For the purpose of: <input type="checkbox"/> Continuity of Care <input type="checkbox"/> Treatment Planning <input type="checkbox"/> Discharge Planning <input type="checkbox"/> Other:			
<p>You have the right to revoke this authorization, in writing, at any time by sending a written notification to our office address. However, your revocation will not be effective to the extent that we have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer have a legal right to contest a claim.</p> <p>I understand that the information in my health care record may contain information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol or drug abuse.</p> <p>I understand that services are not conditioned upon my signing an authorization unless the services are provided to me for the purpose of creating health information for a third party.</p> <p>I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPPA Privacy Rule. This consent will expire: <u>One Year</u> .</p>			
_____ Signature of Patient (if 18+ years old)		_____ Date	
_____ Signature of Mother/Legal Guardian #1 (if patient is under 14 years old) *If joint legal custody exists, both parents/guardians must sign		_____ Date	
_____ Signature of Father/Legal Guardian #2 (if patient is under 14 years old)		_____ Date	
_____ Signature of Witness (if 18+ years old)			
<p>To Recipient: This information has been disclosed to you for your records alone. Confidentiality is protected by Federal Law. Federal Regulation 42FR, part 2, prohibits you from making any further disclosure of this information, in writing or otherwise, without the specific written consent of the person whom it pertains or as provided by such regulations.</p>			