Swapnila Das, PhD
Licensed Psychologist

1000 Heritage Center Circle
Office Number 118,
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Authorization to Use and/or Disclose Medical Records

AUTHORIZATION TO USE AND/OR DISCLOSE MEDICAL RECORDS

I authorize (Your Psychologist) (Swapnila Das) to use and/or disclose a copy of the specific health and medical information identified below for (name of patient) _____ to _____ (name and address of recipient) for the following purposes: (describe each purpose of use / disclosure)

_____
_____
_____

By initialing the spaces below, I specifically authorize the use and/or disclosure of the following health information and/or medical records, if such information and/or records exist:

_____ Please send the entire medical record (all information) as allowed under HIPPA regulations to the above named recipient.
_____ All hospital records (including nursing records and progress notes)
_____ Clinician office chart notes
_____ Dental records
_____ Transcribed hospital reports
_____ Laboratory reports
_____ Medical records needed for continuity of care
_____ Pathology reports
_____ Most recent five-year history
_____ Diagnostic imaging reports
_____ Emergency and urgent care records
_____ Billing statements
_____ Other: _____
_____

* The following items must be initialed to be included in the use and/or disclosure of other health information:

_____ HIV/AIDS related information and/or records

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_____ **Mental health information and/or records**
_____ Genetic testing information and/or records
_____ Drug/alcohol diagnosis, treatment or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed.)
Describe: _____

_____

_____

I understand that, if the person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I also understand that the person I am authorizing to use and/or disclose the information may receive compensation for doing so.

I further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information to be used and/or disclosed under this authorization.

Finally, I understand that I may revoke this authorization in writing at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization. Unless revoked earlier, this authorization will expire 180 days from the date of signing or until (insert applicable date or event)

_____ _____
Signature of Patient or Patient's Legal Representative Date

_____
Print Patient's Name

_____ _____
Print Name of Legal Representative (if applicable) Relationship to Patient

(A copy of this signed form will be provided to the patient.)

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