Swapnila Das, PhD
Licensed Psychologist

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Authorization to Use and/or Disclose Medical Records

AUTHORIZATION TO USE AND/OR DISCLOSE MEDICAL RECORDS

I authorize (Your Psychologist) to use and/or disclose a copy of the specific health and medical information identified below for_____ to _____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) 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
_____ Mental health information and/or records
_____ Genetic testing information and/or records

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_____ 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 _____.

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

_____
Print Patient's Name

Patient's Social Security Number Patient's Date of Birth

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

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