Behavioral Medicine Specialists, P.A.

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AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Patient:

Name of Patient/Previous Names _____ Date of Birth/Medical Record Number _____

Street Address _____ City, State, Zip _____

Authorizes:

Name of Health Care Provider/Plan/Other _____

Street Address _____

City, State, Zip _____

Release of Protected Health Information To:

Name of Health Care Provider/Plan/Other _____

Street Address _____

City, State, Zip _____

Information To Be Released:

__ Psychological Information Including Reports
__ Psychological Testing Information
__ Verbal Communication
__ Written Communication
__ Other (Specify): _____

__ Medical History/Examination/Reports
__ Treatment or Tests
__ Laboratory Reports
__ Surgical Reports

__ Hospital Records including Reports
__ X-ray Reports
__ Prescriptions
__ Entire Record

Purpose For Need Of Disclosure: (Check applicable categories)

__ Further Medical Care
__ Insurance Eligibility/Benefits
__ Other (Specify): _____

__ Legal Investigation or Action
__ Changing Physicians

__ Personal

I understand that if the person(s) and/or organization(s) llisted above are not health care providers, health plans or health care clearinghouses who must follow federal privacy standards; the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information may be redisclosed without obtaining my authorization.

Your Rights With Respect to this Authorization:

Right to Inspect or Copy the Health Information to Be Used or Disclosed – I understand that I have the right to inspect or copy the health information I have authorized to be used or disclosed by this authorization form. I may arrange to inspect my health information by contacting the Privacy Officer at BMS, P.A. **Right to Receive Copy of This Authorization –** I understand that if I agree to sign this authorization, which I am not required to do, I must be provided with a signed copy of the form. **Right to Refuse to Sign This Authorization –** I understand that I am under no obligation ro sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. **Right to Withdraw This Authorization –** I understand written notification is necessary to cancel this authorization. To obtain information on how to withdraw my authorization or to receive a copy of my withdrawal, I may contact the Privacy Officer at BMS, P.A. I am aware that my withdrawal will not be effective as to the uses and/or disclosures of my health information that the person(s) and/or organization(s) listed above have already made in reference to this authorization.

Expiration Date: This authorization is good until the following date(s) _____ or for one year from the date signed.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes.

Signature of Patient or Legal Representative: _____ **Date:** _____
(if signed by other than patient, state relationship and authority to do so)

Signature of Witness: _____ **Date:** _____