AUTHORIZATION TO RELEASE PROTECTED PSYCHIATRIC & PSYCHOLOGICAL HEALTH INFORMATION

Patient's Name _____ Date of Birth _____

This release is to authorize _____ *(name of provider)* of _____ *(address of provider)* to release my protected health information consisting of initial psychiatric evaluation, clinical summary, and progress notes, to Dr. Ani Hawkinson, HeartSong Health In Community for the purpose of coordination of care. Dates of care beginning from _____ (date) and including all care subsequent to this date unless I terminate this authorization in writing.

This authorization also authorizes _____ *(name of provider)* to exchange verbal or written communication for facilitating care during the course of treatment.

- I understand that the information for disclosure may relate to: mental illness, drug and alcohol treatment or HIV/AIDS related illness and is protected under the federal regulations covering Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. parts 160 and 164, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

- I understand that I may inspect or copy the protected health information described in this authorization.

- I understand that the information used or disclosed pursuant to this authorization could be subject to redisclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

- I understand that this authorization is voluntary and can be revoked in writing at any time, except to the extent disclosure has already occurred.

- A photocopy of this authorization shall be considered valid.

_____ _____

Patient's/Guardian's Signature *Date*

HeartSong Health In Community
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