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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name: ____ DOB: ______________________

The person named above hereby authorizes __Suie Chang, PsyD__ (requesting provider) to:
□ Request Health Information from □ Discuss Information with □ Send Information to

The person named above authorizes information to be requested/released by representatives of:

Name (Provider or Facility): ____

Address: ____

Phone: _________________________________ Fax:_______________________________

Specific Health Information Authorized:

□ I authorize disclosure of all my health information, including information relating to medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information;
or
□ I authorize only the disclosure of the following information: ____________________________
____

I understand and agree that:

- This authorization is voluntary;
- My health information may contain information created by other persons or entities including health care providers and may contain medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information;
- I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by my health care provider, except to the extent that the information being requested may assist your health care provider in determining appropriate treatment.
- My health information may be subject to re-disclosure by the recipient, and if the recipient is not a health plan or health care provider, the information may no longer be protected by the federal privacy regulations;
- This authorization will expire one year from the date I sign the authorization. I may revoke this authorization at any time by notifying my provider in writing; however, the revocation will not have an effect on any actions taken prior to the date my revocation is received and processed.

Authorization:

Signature of Patient or Authorized Representative: _______________________________________

Date: _________________________ Relationship if not Patient: ____________________________