GHPA
Greater Houston Psychiatric Associates, PLLC

Authorization for Use or Disclosure of Protected Health Information

Name of Individual: _____ **Date of Birth:** _____

I, the undersigned, authorize the following to disclose the above individual's protected health information:

_____
(Name of health care provider or entity authorized to disclose this information) (Phone) (Fax)

_____
(Mailing Address)

TO: _____
(Name of person or entity who can receive and use this information) (Phone) (Fax)

_____
(Mailing Address)

Disclosure of information for the following purpose(s):

☐ Continued Care ☐ Legal ☐ Insurance ☐ Employment ☐ Education ☐ Personal Use
☐ Other: _____

Information to be disclosed: My medical records may include information regarding diagnosis and treatment of DRUG, ALCOHOL, ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS), (HIV Serology) or PSYCHIATRIC DISORDERS. I understand that such information is confidential and is protected by federal law. HIPAA covered entities receiving this information are advised that federal regulation (42 CFR Part 2) prohibit their making any further disclosure without my written consent, or as otherwise permitted by such regulations. Information to be released includes:

☐Summary of treatment goals and progress ☐Treatment dates ☐Psychiatric evaluation ☐Psychosocial
☐Discharge and Aftercare Plan ☐Medication Record ☐Lab reports ☐Progress Notes ☐Treatment Plan
☐Demographic information ☐Complete Record ☐Other: _____

I ☐do ☐do not authorize this information to be disclosed electronically.

Effective Time Period: This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; permission is withdrawn; 180 days following the date of the signature, or the following specific date (optional): Month_____ Day_____ Year _____

I understand that this authorization is voluntary and that treatment, payment, enrollment or eligibility for benefits cannot be conditioned on the signing of this authorization.

I understand that this authorization can be withdrawn by me at any time by giving written notice stating my intent to revoke this authorization to Greater Houston Psychiatric Associates. I cannot, however, take exception to actions that have taken place before I withdrew my authorization.

I understand that the information disclosed by this authorization 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.

I understand that I have a right to have a copy of this signed form provided to me at the time of signature.

Signature Authorization: I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of heath information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including for the purposes of treatment, payment, or healthcare operations.

_____
(Signature of Individual or Individual's Legally Authorized Representative) (Date)

_____
(Printed Name of Legally Authorized Representative)

If representative, specify relationship to the individual: ☐Parent of minor ☐Legal Guardian ☐Other_____