AUTHORIZATION TO USE/DISCLOSE HEALTH INFORMATION
Read entire document before signing

Patient Name: _______________________________ Date of Birth ______________________

This authorization gives Med Psych Services permission to use and/or disclose health information about you, in accordance with this form.

1. **User/Recipient:** The covered health information (see Number 2, below) may be used by and/or disclosed to the following individual(s) or organization(s):

   Name ____
   Address ____

   Name ____
   Address ____

2. **Covered health information:** The following health information is covered by this authorization (except as limited below):

   - ❑ Patient's Medical Records (including all items below except Billing information)
   - ❑ Treatment notes, which may include medical history, psychiatric diagnosis, substance use history, and other mental health information
   - ❑ Imaging Studies (X-ray, MRI, EMG)
   - ❑ Laboratory Reports
   - ❑ Billing information (Claims, Explanation of Benefits)
   - ❑ Other (please give specific description)

   ____
   ____

   Psychotherapy notes are not covered unless specifically included in a <u>*separate*</u> *authorization. Psychotherapy notes are notes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. Please note that other mental health and behavioral information included in any checked category will be covered by this authorization unless excluded under Item 3 below.*

3. **Specially protected information**: The following information is specially protected by state and/or federal law. Please indicate below whether you would like the following information to be released:

Substance abuse records (drug or alcohol)	Yes ❑	No ❑	Initials ____
Mental health records	Yes ❑	No ❑	Initials ____
HIV/AIDS related information	Yes ❑	No ❑	Initials ____

4. **Other restrictions**: Please specify any other restrictions on the covered information: ____

5. **Purpose**: I am requesting use or disclosure of the covered health information for the following purpose(s) (select all applicable purposes):

   - ❑ My personal use
   - ❑ Further medical treatment
   - ❑ Insurance eligibility or benefits
   - ❑ Eligibility for disability benefits
   - ❑ Legal investigation or action
   - ❑ Other (please describe) ___________________________________

6. I understand that I have the following rights:

   - **Right not to sign.** You may refuse to sign this authorization. Refusal to sign will not affect your ability to obtain treatment by Med Psych Services except when health services are solely for the purpose of reporting to a third party. An example is a pre-employment physical.
   - **Right to revoke.** You may revoke this authorization at any time. Your revocation will not apply to any actions that we have already taken in reliance on this authorization. To revoke this authorization, you must submit a written revocation to our Privacy Officer at the following address:

     Privacy Officer
     5163 West Woodmill Drive, Suite 13
     Wilmington, Delaware 19808
   - **Re-disclosure.** You understand that once the covered health information has been disclosed, it may be no longer protected by privacy laws and may be re-disclosed by the recipient.

7. **Expiration**. This authorization expires as of the following date or event, or 180 days from the date of signature below: ____

I have read and understand this authorization and authorize the use or disclosure of the covered health information as described in this authorization.

❑ Yes, I want a copy of this Authorization
❑ No, I do not want a copy of this Authorization

Signature of Patient/Legal Representative: ______________________________ Date: _______________

Name of Patient/Legal Representative (printed): ____

Relationship to Patient: Self Legal Representative (Authority to Act/Relation): __________________