HRC BEHAVIORAL HEALTH & PSYCHIATRY, PA
CONSENT FORM

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Name_____ DOB_____

This form, when completed and signed by you, authorizes the release of protected information from your clinical record to the person(s) you designate.

I authorize the exchange of information between HRC Behavioral Health & Psychiatry and the following:

1. **Primary Care, Referring Physician, or Therapist**
   Name_____ Organization _____
   Office Phone_____ Fax _____
   Address_____ City_____ State_____ Zip_____
   Extent of information to be released includes: Summary of diagnosis and treatment_____
   _____

2. **Other (e.g. a family member, friend, or organization who may call on your behalf about billing, scheduling, etc.)**
   Name_____ Relation to you_____
   Phone_____ Address_____
   City_____ State_____ Zip_____ May they schedule you? **Yes / No**
   Extent of information to be released includes:_____
   _____

3. **Other (e.g. a family member, friend, or organization who may call on your behalf about billing, scheduling, etc.)**
   Name_____ Relation to you_____
   Phone_____ Address_____
   City_____ State_____ Zip_____ May they schedule you? **Yes / No**
   Extent of information to be released includes:_____
   _____

This authorization is only for the limited purpose of obtaining from or releasing information to, and discussing my case with, these individuals or companies for the specific purposes of evaluation and treatment. It shall not be considered a blanket waiver of all privileged and confidential information.

I am requesting this information exchange for the purpose of Continuity of care._____

This authorization will remain in effect for **two years** unless you designate a different time period below. You may revoke this authorization at any time by giving us written notice.
Expiration if different from above: _____

This authorization is fully understood and is voluntarily made on my part.

*Patient's Signature*_____ *Date* _____
OR
Parent or legally appointed representative's signature _____
Relationship if not parent _____ *Date*_____

Witnessed By: _____ *Date*_____

3/2019 revised

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of my information and no longer protected by the HIPAA Privacy Rule.