SD Psychiatry and Wellness
Laura Wakil, M.D.

AUTHORIZATION FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION CLIENT AUTHORIZATION TO RELEASE CONFIDENTIAL PERSONAL INFORMATION (PHI)
Confidentiality of Medical Information Act, California Civil Code Section 56.11, and HIPPA

This authority includes oral and written communication and the furnishing of copies of clinical records.

NOTE TO ALL PATIENTS: Please print clearly and complete this form in its entirety. If the form is not completed in its entirety, your request will not be processed.

I, _____hereby,
(print name)
voluntarily authorize Laura Wakil, M.D.to *release, exchange, receive* my Protected Health Insurance (PHI) concerning myself, and/or dependent obtained in the course of treatment and/or evaluation.

1. Patient Information

Name: _____
Address: _____
SS#: _____
D.O.B: _____
Insurance information _____

2. Identify Person(s) or Organization(s) You Would Like To Release, Exchange, Receive Your Personal Health Information.

Person/Organization:
Name: _____
Relationship:_____
Address: _____
Phone: _____
Fax: _____

This information will be limited to:
____ Psychiatric/medical/alcohol/drug abuse evaluation
____ Progress notes. ____Psychological testing.
____ Educational testing.
____ Lab studies.
____ Other:
____ Medical tests/studies.

This authorization is valid until _____/_____/_____.

Person/Organization:
Name: _____
Relationship:_____
Address: _____
Phone: _____
Fax: _____

This information will be limited to:
____ Psychiatric/medical/alcohol/drug abuse evaluation
____ Progress notes. ____Psychological testing.
____ Educational testing.
____ Lab studies.
____ Other:
____ Medical tests/studies.

This authorization is valid until _____/_____/_____.

Person/Organization:
Name: _____
Relationship:_____
Address: _____
Phone: _____
Fax: _____

This information will be limited to:
____ Psychiatric/medical/alcohol/drug abuse evaluation
____ Progress notes. ____Psychological testing.
____ Educational testing.
____ Lab studies.
____ Other:
____ Medical tests/studies.

This authorization is valid until _____/_____/_____.

No PHI can be released thereafter. I understand that I may revoke or modify this authorization, but must do so in writing to Dr. Wakil. I understand that this cannot change the fact that some PHI may have been sent to be shared before this date. I also understand that:
a. I do not have to sign this authorization. My refusal to sign will not affect my abilities to obtain treatment.
b. I may inspect and have a copy of the PHI described in this authorization.
c. If the person or entity receiving my PHI is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.

I hereby release SD Psychiatry and Wellness from any legal liability that may arise from my authorizing them to release, exchange, or receive this confidential information. I understand that I have a right to receive a copy of this information. I affirm that

everything in this form that was not clear has been explained, and I believe that I now understand all of it.

_____
Signature of Client or Personal Representative

_____
Date

_____
Describe authority of Personal Representative

I, Laura Wakil, M.D., have discussed the issues above with the client / personal representative. Observations of his/her behavior give me no reason to believe that he/she is not fully competent to give informed/willing consent.

Other Important Information

*The protected health information provided under this authorization may include diagnosis and treatment information, including information pertaining to chronic diseases, behavioral health conditions, alcohol or substance abuse, communicable disease (including HIV/AIDS, and/or genetic marker information). These records will be included in the information and will be made available to the individual or organization you have identified above.

*The information to be disclosed may be protected by the law. Information disclosed under this authorization may be re-disclosed by recipient and no longer protected by the federal privacy regulations.

*Your ability to receive health care treatment from the practice will not be affected if you do not sign this form. However, without your signature, your request to release the information described above will not be honored.

*You may receive a copy of this form by writing to the address listed at the top of this form. This authorization will expire one year from the date you sign this form. If you sign this form, you may revoke the authorization at any time by notifying the practice in writing at the address above. Revoking this authorization will not have any effect on action that the practice took in reliance on the authorization before the practice received notice of your revocation.