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AUTHORIZATION FOR RELEASE OF INFORMATION TO THIRD PARTIES

For this authorization, "My Health Information" means (check all that apply) and may include information regarding substance abuse treatment:

☐ Complete Record (All)	☐ Diagnostic Test / Results (lab, x-rays, and other test results)	
☐ Discharge Summary	☐ Medications / Prescriptions	☐ Psychosocial Assessment
☐ Outpatient Health Records	☐ Drug & Alcohol Treatment Record	
☐ Mental Health Records	☐ Admission History & Physical	☐ Emergency Room Record
☐ Psychiatric Evaluation / Diagnosis	☐ History of Allergies	☐ Classroom Observation
☐ Psychological / Educational Report	☐ Immunization Record	☐ Pathology Report
☐ Psychiatric Admission Note	☐ Verbal Communication	☐ Progress Notes

Other: _____

For the date(s) of service starting / ending: _____
[insert date(s) of service requested]

I authorize Jennifer Teitelbaum Palmer, M.D., to

_____release My Health Information to or

_____receive My Health Information] from:

[insert name of person, hospital, agency, or program]

[insert street address]

[insert city, state and zip code]

This authorization is valid for one year from the date signed, unless I revoke this authorization in writing, or unless an earlier date is specified here: _____

I understand that one My Health Information is disclosed as requested in this authorization My Health Information may no longer be protected by federal and state privacy laws and potentially may be re-disclosed by the person who is receiving my information.

By signing this authorization, I understand that medical records released may contain information related to HIV status, AIDS, sexually transmitted diseases, mental health, drug and alcohol abuse, etc.. I understand that release of psychotherapy notes requires an additional authorization.

Notice to the individual signing this form: The confidentiality of information concerning alcohol and drug abuse treatment is protected by federal law (Federal Regulation 42 CFR Part 2) and prohibits the recipient from further disclosing this information exception with specific written authorization of the person to whom it pertains. A general authorization for release of medical or other information is not sufficient.

I may revoke this authorization by mailing or faxing my written request along with a copy of the original authorization to Dr. Palmer.

If I am unable to provide a copy of the original authorization with my request to revoke, I will provide the following information:

1. Date of the authorization
2. Name
3. Address
4. Phone number
5. Medical record number
6. Date of birth
7. Purpose of authorization
8. A description of the health information covered by the authorization
9. The person or entity authorized to receive / send the information to Dr. Palmer

If the form was signed by my representative, the request will also include:

1. The representative's name
2. Relationship
3. Address
4. Phone number

I understand that if I am unable to provide all of the above information, Dr. Palmer may not be able to honor my revocation request.

I am not required to sign this authorization. If I do not sign this authorization, Jennifer Teitelbaum Palmer, M.D., will not disclose My Health Information as requested. I will receive a copy of this authorization upon signature.

Name (printed)

Signature

Date of Signature

Address

Phone Number

Date of Signature

As the healthcare agent / court appointed guardian / parent / informal kinship care relative [please circle one], I,

Name of Representative (printed)

confirm that I am the representative for the patient as circled above.

Signature of Representative

Address of Representative

Phone Number of Representative