Initials: ______

psychiatrie.me

AUTHORIZATION TO RELEASE AND DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: ______________________________ Date of Birth: ______________

Address: ______________________________ Phone: ______________

City: ______________ State: __________ Zip Code: ______________

I HEREBY AUTHORIZE *PSYCHIATRIE.ME PLLC* TO:

__ Exchange Information With: __ Release Information To: __ Obtain Information From:

Name of Individual/Organization: ______________________________

Address: ______________________________ Phone: ______________

City: ______________ State: __________ Zip Code: ______________

The information to be released may be from my electronic health record and/or paper medical records. I understand that the data from the electronic health record are current as of the date printed.

FOR INFORMATION PERTAINING TO:

__ All Records
__ Psychiatric Evaluations / Consultations
__ Doctor's Notes / Progress Notes
__ Other (Specify): __________

FOR THE TIME FRAME:

__ Entire Record
__ Other (Specify): __________

FOR THE PURPOSE OF:

__ Coordination of Care
__ Other (Specify): __________

Andrés Abreu, MD
Psychotherapy &
Psychopharmacology

PO Box 1198 Southwest Harbor, ME 04679
207.200.8330 psychiatrie.me

psychiatrie.me

AUTHORIZATION TO RELEASE AND DISCLOSE PROTECTED HEALTH INFORMATION

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION:

__ I DO ___ I DO NOT Authorize disclosure of information relating to diagnosis or treatment of ALCOHOL or SUBSTANCE USE DISORDER.

__ I DO ___ I DO NOT Authorize disclosure of information relating to diagnosis or treatment of a PSCYHIATRIC DISORDER or MENTAL ILLNESS.

I understand that:

- I can refuse to disclose some or all of the health care information in my record, but refusal may result in an improper diagnosis or treatment, denial of coverage for a claim for health benefits, or other insurance or other adverse consequences;
- I can withdraw all or part of this authorization at any time during this time period by communicating my request to *psychiatrie.me PLLC* through written or verbal means, and except where this authorization already has been acted on for release of my protected health information. I understand that such revocation may be the basis for denial of health benefits or other insurance or other adverse consequences;
- If protected health information is disclosed to a third party, the information may no longer be protected by the federal or state privacy laws and may be re-disclosed by the individual or entity that receives this information;
- I have the right to access or copy the protected health information described in this form by making a written or verbal request to *psychiatrie.me PLLC*. A copying fee may be charged as permitted by law. I have a right to review my records prior to the release of those records, within 3 working days of the request; and
- I am entitled to a copy of this authorization, upon request.

This authorization is effective for one (1) year from the date of signing. I authorize future disclosures to the same individual and/or entity during this time period pursuant to this authorization.

____________________________________ ________________
Signature of Patient Date

____
Printed Name of Patient

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ME | VT | MA | NH