Weekend Behavioral Health

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Authorization to Release and/or Obtain health Information

Patient Name: ____ Date of Birth:___________________

*Check all that apply

___ I hereby authorize Dr. Wang to release my medical information to _____________________________.

___ I hereby authorize Dr. Wang to obtain medical information from ______________________________.

Address of Individual or Facility: ____

____

Telephone of Individual or Facility: ___________________________ Fax: ____________________________

Information to be Released/Obtained: Check all that apply:

___ History and Physical

___ Progress Notes

___ Consultations

___ Discharge Summary

___ Operative Reports

___ EKG Report

___ Laboratory Reports

___ Radiology Reports

___ Outpatient Clinic Records

Client or responsible party (if application) Initial: _____

___ Emergency Medicine Report

___ Other Diagnostic Reports

___ Immunizations/Vaccinations

___ Other: ____

Specific Authorizations: Check all that apply:

___ I authorize the release of information pertaining to drug and alcohol abuse diagnosis or treatment.
___ I authorize the release of information pertaining to mental health diagnosis or treatment.

___ I authorize the release of HIV/AIDS testing information

___ I authorize the release of genetic testing information

Purpose of Release/Obtaining Medical Information: Check all that apply:

___ Coordination of Care

___ Continuity of Care

___ Billing and payment

___ At request of client or client representative

___ Other: ____

Effective Date of Authorization: __________________ Duration of Authorization: __________________

Please Note: Dr. Wang, like many other health organizations, physicians, hospitals, and health plans, is required by state and federal law to keep your health information confidential. For full details of Dr. Wang's privacy policies, please refer to the Notice of Privacy Practices. If you do authorize disclosure of your protected health information to an individual or organization who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

My Rights

- I understand this authorization is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization except if the authorization is for: 1) conducting research-related treatment, 2) to obtain information in connection with eligibility or enrollment in a health plan, 3) to determine an entity's obligation to pay a clam, or 4) to create health information to provide to a third party. Under no circumstances, however am I required to authorize the release of mental health records.

Client or responsible party (if application) Initial: _____

- I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Dr. Wang and/or the healthcare professional or facility listed above. I understand that the revocation will not apply to information that has already been released in response to this authorization.

- I am entitled to receive a copy of this Authorization.

Client name (please print): _______________________________________ Date: _____________________

Client name's signature: ____

Responsible party (please print): _______________________________________ Date: _________________

Relationship between responsible party and client: ____

Responsible party name's signature: ____

Client or responsible party (if application) Initial: _____