

Email:robert@robertwhitemd.com

AUTHORIZATION FOR DISCLOSURE/USE OF PROTECTED HEALTH INFORMATION

Patient: _____ Date: _____

Birthdate: _____ Dates of treatment: _____

You may use or disclose the following health care information:

- All my health information maintained by Robert S. White, MD
- All my health information maintained by _____
- My health information relating to _____
- My health information for the date(s) _____
- Other _____

You may obtain this health information from:

Name or agency _____

Address _____

You may disclose this health information to:

Name or agency _____

Address _____

Reasons for this authorization

- At my request
- Other _____

The purpose of such information is to assist in diagnosis and treatment of my psychiatric and/or chemical dependency disorder.

I understand that the confidentiality of psychiatric records is required under Chapter 899 of the Connecticut General Statutes and HIPAA of the federal government. Such information shall not be transmitted to anyone without written consent.

I understand that the medical record to be released may also contain confidential psychiatric, HIV, or AIDS related information.

This authorization may be revoked by me at any time except to the extent that action has been taken in compliance with this request. This authorization expires in six months from this date or on _____ date

Signature of patient

Witness

Signature of parent/guardian (if patient is under 18)

