LAVERDURE
PSYCHIATRY

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ **Date of Birth: _____/_____/_____**

Date of Service: _____

I request and authorize name: _____

Address: _____

Phone: _____ **Fax: _____**

City: _____ **State: _____** **Zip Code: _____**

To release healthcare information on the above patient to Laverdure Psychiatry, PLLC.

Information to Be Disclosed:

(I understand that this may include information relating to alcohol and/or drug abuse, behavioral health and/or other highly confidential information obtained during the course of my diagnosis and treatment.)

I authorize the release of any records regarding drugs, alcohol, or mental health treatment to the person(s) listed above.

❑ Complete Medical Records		
❑ Laboratory Results	❑ History and Physical	❑ Emergency Room Visits
❑ Consultations	❑ Imaging Results	❑ Surgical Results
❑ Chemical Dependency Records	❑ Psychiatric/Psychological Records (including progress notes)	❑ Other

I understand that this authorization is voluntary, and I may refuse to sign this authorization. I further understand that my health care and the payment of my care will not be affected if I do not sign this form. I may inspect or copy the information to used or disclosed, and that information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state privacy regulations. Laverdure Psychiatry may charge a processing fee for this service. This authorization will expire by law 180 days from the date of this authorization unless I otherwise specify. I further understand that I may revoke this authorization at any time by notifying Laverdure Psychiatry. If I revoke this authorization I must do so in writing and the written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any action taken before the recipient of the written revocation.

42 CFR part 2 prohibits unauthorized disclosure of these records.

I understand that my substance use disorder patient records are protected under federal regulations 42 C.F.R Part 2 -Confidentiality of Substance Use Disorder Patient Records and cannot be disclosed without my written consent. I do not need to sign this form to obtain treatment. I may revoke this consent in writing at any time. I understand that the revocation will be effective retroactively for information disclosure that have already occurred. If not previously revoked, this consent will terminate either.
THIS AUTHOIZATION EXPIRES 180 DAYS AFTER IT WAS SIGNED.

_____ _____

Signature of Patient OR Person Representative and (description of authority) **Date Signed**

_____ _____

Witness **Date Signed**