SURYA PSYCHIATRIC CLINIC

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

NAME: _____ **PHONE:** _____

FULL ADDRESS: _____

Date of Birth: _____ **MR#** _____

I HEREBY AUTHORIZE: Dr. Tejaskumar B. Patel at Surya Psychiatric Clinic, PLLC
6650 N Oracle Road, Suite 110
Tucson, AZ 85704
Fax: 520-639-8635

☐ to disclose to: ☐ to receive from: ☐ to exchange with

NAME: _____

FULL ADDRESS: _____

PHONE: _____ **FAX:** _____

The following specific information from my records:

- ☐ Verbal Information
- ☐ Psychiatric Evaluation
- ☐ Psychological Evaluation
- ☐ Lab Reports, Imaging Studies, EKG,EEG
- ☐ Assessment Summary
- ☐ Progress Notes
- ☐ Discharge Summary
- ☐ Psychotherapy Notes
- ☐ Medication List
- ☐ Medical History/Physical Exam
- ☐ Other _____

The purpose of this disclosure:

- ☐ Co-ordination of care
- ☐ Transfer of care
- ☐ Evaluation
- ☐ Treatment
- ☐ Follow-up Care
- ☐ Other: _____

I understand that the information in my health records may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. I understand that treatment services are not contingent upon my decision concerning this release of information, I may revoke this authorization, in writing, at any time except to the extent that information already released pursuant to this consent cannot be recalled. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.

This authorization is effective until withdrawn in writing by patient or guardian. A copy or fax of this authorization will be deemed as valid as the original. Please call Surya Psychiatric Clinic, PLLC at 520-639-8576, for further questions or problems.

Patient/Legal Guardian Signature: _____ **Date:** _____

Print Name: _____ **DOB:** _____ **MR#** _____