SURYA PSYCHIATRIC CLINIC

Strive TMS Centers
SHIFTING THE PARADIGM

CONSENT TO RELEASE HEALTH INFORMATION

Dr. Tejaskumar B. Patel at Surya Psychiatric Clinic, PLLC and Strive TMS Centers
6650 N Oracle Road, Suite 110
Tucson, AZ 85704
Phone: 520-639-8576
Fax: 520-639-8635

As set forth more fully in our Notice of Privacy Practices, we are required by law to obtain your authorization for any use or disclosure of your health information for purposes other than treatment, payment, or health care operations. In our Notice of Privacy Practices, we provided you information about how Surya Psychiatric Clinic, PLLC and Strive TMS Centers can use or disclose your health information. You have a right to review our Notice of Privacy Practices before signing this authorization.

Please neatly PRINT (except signature) and provide complete information in each section.

Patient's Legal Name _____

Birth Date _____

Authorization for Surya Psychiatric Clinic, PLLC and Strive TMS Centers to receive information☐

Authorization for Surya Psychiatric Clinic, PLLC and Strive TMS Centers to release information☐

By signing this form, I am allowing Surya Psychiatric Clinic, PLLC and Strive TMS Centers to release or obtain medical information concerning the above named patient to or from the person or facility listed below. If you are requesting information for yourself or for a third party, Surya Psychiatric Clinic, PLLC and Strive TMS Centers will assess appropriate and reasonable fees for the copying of such information. Such fees will comply with all state and federal laws.

Name of Person and/or Institution who will **receive or release** information:

_____

Complete Mailing Address:

Street or PO Box: _____

City, State, Zip Code_____

Check the information to be disclosed (include dates if known):

☐ I authorize the release of my complete health record (including records relating to mental health care, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse.

☐ I authorize the release of my complete health record with the exception of the following information:

- ☐ Mental health records
- ☐ Communicable diseases (including HIV and AIDS)
- ☐ Alcohol/drug abuse treatment
- ☐ Genetic Testing
  Refers to genetic testing to screen for possible future health issues, does not refer to testing to diagnose or treat current health conditions.
- ☐ Other (please specify): _____

I understand that if I authorize the release of Drug & Alcohol Abuse treatment records that Federal Law protects those records. The authorization for Release of Information form does not authorize re-disclosure of medical information beyond the limits of this consent. Federal Law (42 CFR Part 2) for Alcohol/Drug abuse, prohibits information disclosed from records protected by this law from being re-disclosed, even to the

patient, without a specific written consent of the person to whom it pertains or as otherwise permitted by such law and/or regulations. A general authorization for the release of medical or other information is NOT sufficient for these purposes. Federal rule restricts any use of the information to criminally investigate or prosecute the patient.

Please check the reason for sending or receiving information below; and provide a date by which the info is needed: _____

Insurance ____ 2nd Opinion _____ Rehab/Disability _____ Personal file _____ Moving Out of Area _____ Legal _____ Other medical care _____ Transferring care _____

If transferring care, may we confidentially discuss this with you? YES ___ NO___
If yes, please indicate the best time and telephone number to reach you:
_____

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 and Strive TMS Centers at 520-639-8576, for further questions or problems.

Surya Psychiatric Clinic, PLLC and Strive TMS Centers does not require completion of this form as a condition of evaluation or treatment. However, when the requested evaluation or treatment is solely for the purpose of creating a medical report for a third party, if authorization to release the information to that third party is not provided, it may result in the cancellation of those services.

Print Name: _____

Signature: _____

Date: _____

Relationship, if Not the Patient: _____

Witness Signature _____