Orange Psychiatric Medical Group, Inc.

Authorization for Release of Protected Health Information for Mental Health/Chemical Dependency

Check the box that applies: **Dates of Treatment:_____**

- ○ **Release my OPMG records to**
- ○ **Obtain my records from**
- ○ **Release billing summary to**
- ○ **Patient Access (provide documentation of you are patient representative)**
- ○ **Make records available for review (Confirm record review appointment)**

_____

Individual/Agency Name

_____

Address

_____

City **State** **Zip Code**

Records release are authorized for the following purpose: **Please circle:**

Continued Care **Personal Use** **Other:_____**

I understand authorizaing the disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment. 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 the Medical Record Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition:_____ If I fail to specify an expiration date, event or condition, this authorization will expire **twelve months from the date of signature**. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in HIPAA. I understand that any disclosure of information carries with it the potential for an unatuhorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Medical Records Department.

Patient name:_____DOB:_____

SSN#_____Phone#:_____

_____ _____ _____

Signature of Patient/Legal Representative **Date** **Relatinship to Patient**