TRIANGLE PSYCHIATRIC SERVICES, PA

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AUTHORIZATION TO DISCLOSE AND EXCHANGE HEALTH INFORMATION

Complete all required fields. Keep a copy of the signed authorization.

1. Patient information

Patient name: _____ **Date of birth:** _____

Preferred phone: _____ **Email:** _____

2. Direction and other person or organization

Check at least one:

☐ TPS may disclose TO the party below ☐ TPS may obtain FROM the party below ☐ TPS and the party below may exchange both ways

Person / organization: _____

Street address: _____

City / state / ZIP: _____ **Phone:** _____ **Fax:** _____

Secure email (if used): _____

3. Information authorized

Check at least one category. Only the categories checked may be disclosed or obtained.

☐ Entire designated record* ☐ Psychiatric evaluation / diagnoses ☐ Medication and prescribing records

☐ Treatment plans / clinical summaries ☐ Progress notes* ☐ Discharge summary

☐ Laboratory / medical test results ☐ Psychological / educational testing ☐ Billing / attendance information

Other (describe specifically): _____

Date range: All records maintained through expiration, unless a narrower range is written: **From:** _____ **To:** _____

*Important exclusions: This authorization does not include psychotherapy notes as defined by HIPAA, SUD counseling notes, or records protected by 42 CFR Part 2. A separate, specific authorization or Part 2 consent is required when applicable.

4. Purpose, delivery, and expiration

☐ Treatment / continuity of care ☐ At my request ☐ Insurance / disability / legal **Other:** _____

Preferred delivery (optional): ☐ Secure fax ☐ Secure email ☐ Mail ☐ Patient pickup / portal

Expiration: One year after the date signed, unless I specify this earlier date or event: _____

5. Your rights and authorization

I understand that: (1) I may revoke this authorization at any time by sending a written request to the Privacy Officer at the address above or to medicalrecords@triangle-psychiatric-services-pa.com; revocation will not affect action already taken in reliance on it. (2) TPS will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization, except where law permits otherwise. (3) Information disclosed to a person or organization that is not required to follow HIPAA may be redisclosed and may no longer be protected by HIPAA. (4) I am entitled to a copy of this signed authorization. I authorize the uses and disclosures described above.

Patient / personal representative signature: _____ **Date:** _____

Printed name: _____ **Representative's authority / relationship:** _____