**Veritas Integrated Psychiatric Care, PLLC**

6410 Alpine Ave. NW, Suite A, Comstock Park, MI 49321

P: (616) 647-3330 F: (616) 647-3335

 **RELEASE OF INFORMATION**

**Authorization of Release/Exchange of Protected Health Information**

Patient Name: Date of Birth:

I authorize the release of my medical records from Veritas Integrated Psychiatric Care, PLLC to any verified physicians or peoples involved in the course of my treatment.

I specifically consent to the disclosure of records to relevant healthcare providers, healthcare facilities and diagnostic centers involved in my treatment that ***may*** contain:

* Alcohol/drug/ substance abuse information
* HIV test results or diagnosis of AIDs and AIDs related conditions
* Mental health information

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use of disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

If not previously revoked, this authorization to use or disclose protected health information will expire TWELVE (12) months from the date of my signature OR as otherwise specified by date, event or condition(s) as follows:

I understand that I have the right to revoke this authorization, ***in writing,*** at any time by sending written notification to*: Veritas Integrated Psychiatric Care, PLLC Attn: Privacy Contact 6410 Alpine Ave NW, Suite A, Comstock Park, MI 49321.* I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

The use or disclosure requested under this authorization will result in direct or indirect remuneration to my physician from a third party*. [This is only applicable if authorization is obtained for marketing purposes.]*

I, the undersigned, authorize Veritas Integrated Psychiatric Care PLLC, to use the following forms of communication to share information with the person and/or practice listed below:

□ Verbal

□ Diagnosis and Medications

□ Doctor’s Evaluation and Progress Notes

□ Laboratory Data

□ Other Documents (please specify)

**Person/Practice to release information to:**

NAME:

RELATIONSHIP:

PRACTICE:

ADDRESS:

CITY/STATE/ZIP:

PHONE:

FAX:

**Signature** of Patient or Personal Representative

**Print Name** of Patient or Personal Representative/Guardian

**Relationship** to Patient **Print Name** of Patient or Personal Representative

**Date** **Description of Personal Representative’s Authority**

(Updated 6/8/2015)