AUTHORIZATION FOR TRI CITY PSYCHIATRIC SERVICES, P.A. TO RECEIVE OR DISCLOSE MY PRIVATE HEALTH INFORMATION

Patient Name: _____ Previous Name: _____

Date of Birth: _____ Today's Date: _____

SSN: __-____-_____

(I.) **My authorization**

Tri City Psychiatric Services, P.A. may receive or disclose the following health information:

(Check all that applies)

{ All my health information

{ My health information related to the following treatment or condition: _____ { My health information for the dates: ____/____/_____ Other: _____

Information may be received from or disclosed to the Tri City Psychiatric Services, P.A. by:

	Name or Organization	**Phone #**	**Fax #**
1.			
2.			
3.			
4			

{ Reason for Authorization: { at my request { Other(specify) _____

{ This authorization ends on ____/____/_____

{ When the following event occurs: _____

{ When the patient terminates with Tri City Psychiatric Services, P.A.

(II.) My rights:

I understand I do not have to sign this authorization in order to get health care benefits /treatment/payment, or enrollment). However, I do have to sign an authorization form:

- To take part in a research study
- To receive health care when the purpose is to create health information for a third party

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Tri City Psychiatric Services, P.A. Based upon this authorization, I may not be able to revoke this authorization if, its' purpose was to obtain insurance.

The two ways to revoke this authorization are:

1. Fill out a Revocation form. The form is available from this office.
2. Write a letter to this office.

Signature: Patient / Legal Guardian / POA	Date	Witness	Date

Tri City Psychiatric Services, P.A.
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