HIPAA Release Form

Please complete all sections of this HIPAA release form. If any sections are left blank, this form will be invalid, and it will not be possible for your health information to be shared as requested.

Section I

I, _____, **DOB** _____ give my permission for ___**MD Psychiatry & Emotional Health, PLLC**___ to share the information listed in Section II of this document with the person(s) or organization(s) noted below associated with my treatment:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Other: _____

Section II – Health Information

I would like to give the above healthcare organization permission to:

Please select one:

☐ Disclose my complete health record (H&P, Progress Notes and Discharge Summary) to the parties identified in Section I via written or electronic communications as noted below.

Or

☐ Disclose my complete health record except for the following information to the parties identified in section I via written or electronic communications as noted below:

- ☐ Communicable diseases including, but not limited to, HIV and AIDS
- ☐ Other (Specify) _____

_____

_____

Form of Disclosure:

- ☐ Electronic copy or access via a web-based portal
- ☐ Hard copy

I understand that the person(s)/organization(s) who receive my health record may not be covered by state/federal rules governing privacy and security of data and may be permitted to further share the information that is provided to them.

Section III – Duration of Authorization

This authorization to share my health information is valid:

Mark as appropriate: (**please select one**)

- ☐ a) From _____ to _____
- ☐ b) All past, present, and future periods

I understand that I am permitted to revoke this authorization to share my health data at any time and can do so by submitting a request in writing to **MD Psychiatry & Emotional Health, PLLC.**

Section IV – Telehealth/Telemedicine Acknowledgment

☐I **consent** OR ☐ I **do not consent** to participate in Telehealth/Telemedicine services at MD Psychiatry & Emotional Health, PLLC. I understand that I will not be eligible to be seen via telehealth without my consent.

Section V- Text/Email Written Communications

☐I **consent** OR ☐ I **do not consent** to communicate regarding my Personal Health Information (PHI) through text or email communications and/or through the MD Psychiatry & Emotional Health website.

I understand that:

- In the event that my information has already been shared by the time my authorization is revoked, it may be too late to cancel permission to share my health data.
- I understand that the failure to sign/submit this authorization or the cancellation of this authorization will not prevent me from receiving any treatment or benefits I am entitled to receive, provided this information is not required to determine if I am eligible to receive those treatments or benefits or to pay for the services I receive.

Section IV – Signature

Signature: _____ Date: _____

Print your name: _____

If this form is being completed by a person with legal authority to act an individual's behalf, such as a parent or legal guardian of a minor or health care agent, please complete the following information:

Name of person completing this form: _____

Signature of person completing this form: _____

Describe below how this person has legal authority to sign this form:

_____

_____

_____