Purpose Psychiatry

Consent & Authorization to Use, Exchange, or Disclosure, of Protected Health Information (PHI)

Completion of this document authorizes the disclosure, exchange and use of health information about you. Failure to provide all information requested may invalidate this authorization.

Name of patient: _____

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize: **Purpose Psychiatry and Jeremy R. Verhines, PMHNP-BC**

(specific name(s) or general designation(s) of health entity(ies), individual(s), or Part 2 Program permitted to make disclosure)

to release the following health information about me:

☐ A. All health information pertaining to my medical history, mental or physical condition and treatment received;

OR

☐ B. Only the following records or types of health information (including any dates):_____

_____

_____

AND

☐ I specifically authorize release of the following information (check as appropriate):

- ☐ *Mental health treatment information _____(initial)
- ☐ HIV test results _____(initial)
- ☐ Substance use disorder treatment information _____(initial)

Substance use disorder information subject to this authorization must be explicitly described:_____

_____

_____

32565 Golden Lantern St. #B479
Dana Point, CA 92629
P: 949.205.7802 / F: 949.205.7804
info@purposepsychiatry.com / www.purposepsychiatry.com

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to: (name(s) of individual(s)/entity(ies) authorized to receive the information):

☐ Named individual(s):_____

_____

include person's name and address

☐ Named entity(ies) with treating provider relationship with me:_____

_____

include name of the entity(ies)

☐ Named third-party payer: _____

☐ Named Entity(ies) without a treating provider relationship*_____

_____

*One of the following box(es) **must** also be checked and completed as applicable)

☐ Named individual participant:_____

☐ Named participating entity(ies) with treating provider relationship:

_____

☐ **General designation of individual or entity or class of participants with treating provider relationship: _____

_____

If a general designation is indicated, please confirm your understanding that upon your request, and consistent with 42 CFR Part 2, you must be provided with a list of entities to which this information has been disclosed pursuant to this general designation. **(Patient/patient representative initials)_____

PURPOSE

State the specific purpose(s) of requested use or disclosure (the disclosure will be limited to that information necessary to carry out the stated purpose:_____

_____

_____

_____

Limitations, if any:_____

_____

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OR:

☐ Patient request

OR:

☐ Other:_____

EXPIRATION

Unless revoked sooner, this authorization expires on: _____

_____

(date, event or condition)

MY RIGHTS

☐ I may refuse to sign this authorization. My refusal could affect my ability to obtain services under this specific program, but efforts will be made to offer services under other programs.

☐ I may inspect or obtain a copy of the health information that I am being asked to allow the use or disclosure of.

☐ I may revoke this authorization at any time, either verbally or in writing; if I do so in writing I understand that I may submit my revocation to the following address:_____.
My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.

- I have a right to receive a copy of this authorization and will be offered a copy.
- Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not prohibited by California law and may no longer be protected by federal confidentiality law (HIPAA). For example, if I authorize the disclosure of information to a family member.

☐ Substance use disorder information may not be re-disclosed unless another authorization for such disclosure is obtained from me, or unless such disclosure is specifically required or permitted by law.

SIGNATURE

_____ Date:_____Time:_____am/pm

(signature of patient/patient representative)

Printed name: _____

If signed by a person other than the patient, indicate relationship:

☐ parent/legal guardian of minor
☐ conservator
☐ other:_____

_____

* A separate authorization is required to authorize the disclosure or use of psychotherapy notes, as outlined in the federal regulations implementing the Health Insurance Portability and Accountability Act.

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