## Old Georgetown Mental Health Associates, LLC Authorization to Disclose or Obtain Protected Health Information

My Authorization: You may use or disclose the following health care information (check all that apply)All my health information maintained by	Authorization for	to Use/Disclose N	My Health Information	
Patient name:		(name of clinician)		
You may use or disclose the following health care information (check all that apply) All my health information maintained by				
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My health information-relating to the following treatment or condition: A summary of my health informationVerbal discussion of my health information as needed for clinical careOther:	All my health in:	Formation maintained by	on (eneck an that appry)	
My health information-relating to the following treatment or condition: A summary of my health informationVerbal discussion of my health information as needed for clinical careOther:		(name o	of clinician)	
Vou may disclose this health information to:  Name (or title) and organization:  Address	My health infor	nation-relating to the following treatme	nt or condition:	
Vou may disclose this health information to:  Name (or title) and organization:  Address	A summary of r	ny health information.		
You may disclose this health information to:  Name (or title) and organization:  Address	Verbal discussion	on of my health information as needed for	or clinical care.	
Name (or title) and organization:  Address	Other:			
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Reason(s) for this authorization (check all that apply)  At my request Other (specify)  This authorization shall remain in effect from the date signed below until specifically revoked by me.  Mv Rights I understand that: - I may inspect or copy the protected health information to be used or disclosed I may revoke this authorization in writing at any time by contacting your office, attention Privacy Officer, LaShawn Farrish I may refuse to sign this authorization and understand that you will not condition treatment or payment on me providing this authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide that research-related treatment) I acknowledge that once the office discloses my health information, it no longer controls the information and it is possible that the person or organization	Address	City	State 7in	
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Patient Name/Signature: Date:	Patient Name/Signat	nire.	Date:	
Relationship to Patient (If signed by personal representative of Patient):				