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

Authorization for _____to Use/Disclose My Health Information
(name of clinician)
Patient name: _____Date of birth: _____

My Authorization:
You may use or disclose the following health care information (check all that apply)
___All my health information maintained by _____
(name of clinician)
___ My health information-relating to the following treatment or condition:
_____
___ A summary of my health information.
___ Verbal discussion of my health information as needed for clinical care.
___ Other: _____

You may disclose this health information to:
Name (or title) and organization: _____
Address_____City_____State____Zip_____
Phone:_____

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.

My 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 that receives it may re-disclose it. Privacy laws may no longer protect it.

Patient Name/Signature: _____Date: _____
Relationship to Patient (If signed by personal representative of Patient): _____