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AUTHORIZATION TO RELEASE INFORMATION

I.AUTHORIZATION FOR RELEASE OF INFORMATION AND REDISCLOSURE

I hereby authorize Michael C. March, Ph.D., PLLC to disclose the following information from the health records of:

Patient Name: _____
Last *First* *MI* *Date of Birth*

This information is to be: _____ Exchanged with _____Disclosed to _____ Obtained from

Recipient Name: _____
Name of entity *Address* *Phone*

SPECIFIC RECORDS TO BE AUTHORIZED FOR RELEASE:

___ Discharge Summary ___ Progress Notes ___ Medications
___ Diagnosis/Patient History ___ Treatment Plans ___ Neurological
___ Labs ___ Assessments/Evaluations ___ Other (specify): _____

Unless specified below under 'Limitations' this authorization includes written and spoken disclosures and electronic interchange.
___ *Limitations (please specify):* _____

PURPOSE OR NEED FOR THE DISCLOSURE:

___ Coordination of Care ___ Diagnostic Assessment ___ Management of Insurance
___ Treatment Planning ___ Legal ___ Continuing Care
___ Other: _____

Affirmation of Release

I give the above named agency permission to release only the information I have selected on this form to the individual(s) or entities I have named and only for the purpose I have stated. I understand that this release is valid for one year from the date that I sign it and I may refuse to sign the authorization or revoke the authorization at any time. Any revocation or refusal to sign this authorization will not affect my ability to obtain health care services. The revocation will take effect on the day it is received in writing. As a patient I have a right to access my treatment records during treatment and after discharge. Copies of the records may be obtained by me with reasonable notice and payment of copying costs. I understand that if the person or entity that receives the above specified information is not a health care provider, health plan, or health clearninghouse covered by the federal privacy regulations or a business associate of those entities, the information described above may be redisclosed and no longer covered by those regulations; I further understand that such a non-covered recipient could, without further authorization, redisclose said information to parties and their legal counsel, insurers, reinsurers, experts, potential experts, anyone against whom a claim has been made, administrative agency and court officials hearing the claim, and any agents, employees, or representatives of any said persons. A copy of this authorization shall be deemed the same as the original.

II.SPECIFIC AUTHORIZATION FOR RELEASE OF INFORMATION PROTECTED BY STATE AND/OR FEDERAL LAW CONCERNING MENTAL HEALTH, SUBSTANCE ABUSE TREATMENT, HIV/AIDS-RELATED INFORMATION AND GENETIC INFORMATION

I understand that this will include information relating to the following categories unless I specifically deny the release.
(**Initial** any category **not** to be released)

_____ Mental Health _____ Substance Abuse
_____ HIV/AIDS _____ Genetic Information including genetic test results

_____ _____
Signature of Patient/Guardian/Legal Representative **Date**

_____ _____
Signature of Witness/Relationship to Patient **Date**

Revised 09/04/2017