Maggie Alexander, PMHNP, LLC **Psychiatric Mental Health Nurse Practitioner**

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AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

Client Name ____DOB ______/_____/_____
Street Address: ____
City, State, Zip Code: ________________________/______________/_______________
Telephone Number: ___________________________________

I authorize Maggie Alexander, PMHNP, LLC

Check appropriate box(es) and initial and give complete name and address:

___To give health records to:
___To receive health records from:
___To verbally exchange health information with:

Name: ____
Street Address: _________________________________
City, State, and Zip Code: _________________________
Telephone: ____________________________________
Fax Number: ___________________________________

For the purpose of continuing care or: ____

___ All information in chart

___Specific information to be released:____,
if such information exists:

___Mental health related information
___Drug/alcohol diagnosis, treatment or referral information
___HIV/AIDS related records
___Genetic testing information

As indicated below, the authorization for release extends to the care and treatment the client received during:

_____ All dates of service
______ Service between ___________ and ___________

Required Statements:

This authorization will expire in one (1) year or upon (insert date or event) ___________________________________

I may revoke this authorization in writing by presenting my written revocation to Maggie Alexander, PMHNP, LLC.

The revocation will not apply to information that has already been released in response to this authorization. I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used and/or disclosed under this authorization. Maggie Alexander PMHNP, LLC is not responsible for the cost of copies.

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing information under federal or state law.

Signature of Client*____Date________________________

Signature of Personal Representative____Date________________________

Relationship to Client____

*If patient is 14 years or older form must be signed by patient