RBE
Ramesh B. Eluri, MD.,PC.
Psychiatry & Psychology Services

AUTHORIZATION FORM

Patient Name: _____ Birthdate: _____

This form, when completed and signed by you, authorizes us to release protected health information from your clinical record to/from the person you designate.

I authorize _____ and/or his/her staff to

☐ Release to ☐ Receive from:

_____

_____

_____

_____

The following information (provide detailed description):

_____

_____

I am requesting to release this information for the following reasons ("at the request of the patient" is all that is required if you are the patient and you do not desire to state a specific purpose.):

_____

This authorization shall remain in effect for one year or until (fill in date or relevant event):

_____

You have the right to revoke this authorization, in writing, at any time by sending such written notification to this office address. However, your revocation will not be effective to the extent that we have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that Ramesh B. Eluri, MD.,PC generally may not condition psychological services upon my signing an authorization unless the psychological services are provided to me for the purpose of creating health information for a third party.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of your information and no longer protected by the HIPAA Privacy Rule.

☐I do not want a copy of this form. ☐ A copy of this form has been provided to me.

_____ _____

Signature of Patient Date

_____ _____

Signature of Parent/Guardian for a minor Date

Prohibition of Redisclosure: Confidential health care information has been disclosed to you from records whose confidentiality is protected by state and federal law. These laws, including HIPAA, prohibit you from making disclosures of this information unless further disclosure is expressly permitted by the written Authorization of the person to whom it pertains. A general authorization for the release of medical or other information is NOT sufficient for this purpose. Revised 5/8/2008.

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