CEDAR VALLEY PSYCHIATRY, LLC

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

For yourself and emergency contact/anyone you would like us to release your medical info to.

Patient Name: ____ **Date of Birth:** _____ /_____ /__________

1. I authorize the use or disclosure of the above-named individual's health information described below
2. The following individual(s) or organization(s) is/are authorized to make this disclosure:

CEDAR VALLEY PSYCHIATRY, LLC AND PSYCHOTHERAPY SERVICES
8130 Adams Drive, Hummelstown PA, 17036 **Phone:** 717-967-8288 **Fax:** 717-967-8291

3. The information identified below may be disclosed to or used by the following individual(s) or organization(s):

Name: ____

Address: ____

Phone: _______________________ **Fax:** __________________________

4. The type of information that may be disclosed is as follows:

☐ Diagnostic and medical history ☐ Entire record ☐ Summary Only
☐ Other (Please, give specific description) ____

5. Specially protected information (Please, check all that apply)

☐ I understand that the information to be disclosed may include information relating to AIDS or HIV
☑ I understand that the information to be disclosed includes mental health information:
☑ With psychotherapy notes ☐ without psychotherapy notes
☐ I understand that the information to be disclosed may include information about treatment for drugs, alcohol or substance abuse.

6. This information for which I am requesting disclosure will be used for the following purpose:

☑ My medical treatment ☑ Insurance payment/reimbursement ☑ my personal use
☐ To evaluate my eligibility for life insurance coverage
☐ To evaluate my eligibility for disability benefits ☐ at the request of my attorney:

Name: ______________________________________ **Address:** _____________________________________

Other: (Please, describe) ____

7. I understand that I have the following rights:

7.1 Right not to sign. You may refuse to sign this authorization. Refusal to sign will not affect your ability to obtain treatment by Cedar Valley Psychiatry LLC except when health services are solely for the purpose of reporting to a third party.

7.2 Right to revoke. You may revoke this authorization at any time. Your revocation will not apply any release made in response to this authorization: To revoke this authorization, you must submit a written revocation to:

Cedar Valley Psychiatry (Dr. Gale Georgeff)
8130 Adams Drive, Hummelstown PA, 17036

7.3 Re-disclosure. I understand that once the information listed above has been disclosed, it could potentially be re-disclosed because the information may no longer be protected by federal privacy laws or regulations.

8. Expiration date of event: _____________

I have read and understand this authorization, and authorize the use and/or disclose of the health information as described in this authorization.

Patient signature: (14 year old, parent, legal guardian or other legally-authorized representative)

____ **Date:** _____ /_____ / __________

Name of personal representative if signed above: (please, print): ____

Relationship to patient: ____