Holistic Child Psychiatry, LLC
Phyllis J. Heffner, M.D.
10801 Hickory Ridge Rd
Suite 215
Columbia, MD 21044
(410) 260-0344.

Release of Information Form

I, __________________, hereby authorize the use or disclosure of my/my child's ________________________ protected health information as described below:

1. AUTHORIZED PERSONS TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Holistic Child Psychiatry, LLC is authorized to receive/disclose the following protected health information to
__________________ of __________________, __________________ __________________.

2. DESCRIPTION OF INFORMATION TO BE DISCLOSED

The health information that may be disclosed is:
All past, present, and future periods of health care information may be shared.

3. PURPOSE OF THE USE OR DISCLOSURE

The purpose of this use or disclosure is __________________.

4. VALIDITY OF AUTHORIZATION FORM

This Authorization Form is valid beginning on __________________ and expires on __________________.

5. ACKNOWLEDGMENT

I understand that the information used or disclosed under this Authorization Form may be subject to re-disclosure by the person(s) or facility receiving it and would then no longer be protected by federal privacy regulations.
I have the right to refuse to sign this Authorization Form. If signed, I have the right to revoke this authorization, in writing, at any time. I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

By: ______________________________________ Date: ____________________