Holistic Child Psychiatry, LLC
Holistic Adult Psychiatry

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

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name (print): _____

Date of Birth: _____

By signing this Authorization Form ("Authorization"), I understand that I am giving my authorization to Holistic Child Psychiatry/Holistic Adult Psychiatry, located at10801 Hickory Ridge Rd, Ste 215, Columbia, MD 21044, its employees, designees, agents, independent contractors, legal representatives, successors, and assigns ("Practice") to use and/or disclose my protected health information as described in more detail in the paragraphs below, to the following person(s) or organization(s):

Name of person(s) or organization(s): _____
Street address: _____
City, State, and Zip Code: _____
Telephone number: _____
Facsimile number: _____

I specifically authorize the use and disclosure of the following PHI:
(Please provide a detailed description of the particular data and period of time you are requesting): _____
_____
_____

If this authorization is for any purpose other than the release of medical records for personal reasons, please state the purpose of the authorization to release PHI below: _____
_____
_____
_____

Right to Revoke: I have the right to revoke this authorization at any time by providing written notice of my revocation to the contact person listed below:

Holistic Child Psychiatry/Holistic Adult Psychiatry
Attn: Phyllis Heffner, MD

Please understand that revocation of this Authorization will not affect any action Practice took in reliance on this Authorization before receiving my revocation.

Unless earlier revoked, this Authorization will expire on _____.

I hereby hold harmless and release Practice from all claims, demands and causes of action which I, my heirs, representatives, executors, administrators or any other persons acting on my behalf or on behalf of my estate have or may have by reason of this Authorization.

If neither federal nor state privacy laws apply to the recipient of the information, I understand that the information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal or state privacy law.

I may inspect and receive a copy of the information to be used and disclosed pursuant to this Authorization form.

This Authorization is voluntary and I may refuse to sign this Authorization form.

If I am providing authorization for marketing purposes, I understand that Practice may receive remuneration from a properly authorized business associate as a result of using or disclosing the my protected health information.

I understand that my refusal to sign this Authorization will have no effect on the medical treatment I receive from Practice.

_____ _____

Signature of Patient Date

_____ _____

Signature of Patient's Representative (*if applicable*) Date

_____

Printed name of Patient's Representative *(if applicable)*

_____

Relationship to patient *(if applicable)*