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AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

NAME OF PATIENT _____

DATE OF BIRTH _____

TODAY'S DATE _____

I hereby authorize Dr Gaitskill to disclose and receive my (or my child's) protected health information, as specified below to:

_____

_____

_____

The information to be released includes any psychiatric and medical treatment for the purposes of coordination of care. Unless indicated, this authorization is valid for the duration of treatment. I understand that I may revoke, in writing, this consent at any time, except where information has already been released.

I understand that the information disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by HIPPA or any other federal or state law.

_____

Printed name patient or parent of a minor child

_____

Signature of patient or parent of a minor child