AUTHORIZATION TO DISCLOSE VERBAL HEALTH INFORMATION

The Holiner Psychiatric Group
7777 Forest Lane, C-833, Dallas, TX 75230
Office: 972-566-4591 Fax:972-566-6679

Joel Holiner, MD **Robert Freele, MD** **Wajahat Ali, MD**

Patient Name (please print) _____ Date of Birth _____

Social Security Number _____ Phone # _____

I HEREBY AUTHORIZE DISCLOSURE OF INFORMATION TO/FROM THE NAMED INDIVIDUAL(S) OR ORGANIZATION(S) LISTED:

Full Name	**Relationship to Patient**	**Daytime or cell phone**

☐ Release all Health Information
☐Release all Billing (including payments, collections, ect.)
☐Release Other (Specify):_____

Full Name	**Relationship to Patient**	**Daytime or cell phone**

☐ Release all Health Information
☐Release all Billing (including payments, collections, ect.)
☐Release Other (Specify):_____

Full Name	**Relationship to Patient**	**Daytime or cell phone**

☐ Release all Health Information
☐Release all Billing (including payments, collections, ect.)
☐Release Other (Specify):_____

- **I understand that incomplete forms will be null and void; no exceptions.**
- **I understand that disclosure of my health information does not include mailing or faxing copies of my medical records; I must complete a medical records release in order to have copies of my medical records mailed or faxed to the named individual(s) or organization(s).**
- I understand that specific information to be disclosed may include history of *Drug or Alcohol Abuse* or *Mental Health Treatment,* information concerning communicable diseases such as *Human Immunodeficiency Virus (HIV),* and *Immune Deficiency Syndrome (AIDS),* laboratory test results, treatment progress, and any other such related information. **This authorization will expire 1 year from the date of my signature.**
- I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.
- I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself.
- I further authorize that a photocopy of this authorization is acceptable as an original.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations.
- The practice will not condition my treatment, payment, and enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure. I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to: Privacy Officer: 7777 Forest Lane, Suite C-833 Dallas, TX 75230 **Phone:** 972-566-4591 **Fax:** 972-566-6679

Name of Patient or Personal Representative _____ Date _____

Signature of Patient or Personal Representative _____ Description of Personal Representative's Authority _____

Witness _____ Date _____