ALBARADO PSYCHIATRY - HIPAA Compliant Medical Authorization

[Pursuant to 45 CFR sec 164.508(6)]

Patient Name:		Date of Birth:	
This is an authorization for Albarado Psychiatry, LLC to disclose my healthcare information.			
You may use or disclose the following healthcare information:	( ) Diagnosis ( ) Entire medical record ( ) Initial Evaluation	( ) _____ _____ _____	
You may use or disclose this health information to:	Name and organization: _____ _____	Address: _____ _____	
Purpose of this authorization:	( ) At my request. ( ) Transfer of care	( ) Other: _____ _____	
This authorization ends:	( ) On (date): _____ ( ) one year from today	( ) When the following event occurs: _____ _____	

My Rights:

I understand that I do not have to sign this authorization in order to get healthcare benefits (treatment, payment, enrollment, or eligibility). However, I do have to sign an authorization form to take part in a research study or to receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing by sending a letter to the healthcare provider to whom the authorization is directed. If I did, it would not affect any actions already taken by the healthcare provider based upon this authorization.

I may not be able to revoke this authorization if its purpose was to obtain insurance.

I understand that once the healthcare provider discloses my health information, the person or entity that receives it, may re-disclose it. The HIPAA Privacy laws may no longer protect it.

Patient's Signature:		Date:
Parent's/Guardian's/ Legal authority's Signature:		Date:
Relationship to patient/ Representative's authority to sign on behalf of the patient:		( ) parent ( ) _____