

Patient Name: _____ Date of Birth: _____

Address: _____

MEDICAL RECORDS RELEASE / AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

For all uses and disclosures of a patient’s Protected Health Information (“PHI”), other than those required by law or for treatment, payment and health care operations, The Health Insurance Portability and Accountability Act (“HIPAA”) requires that Evansville Psychiatric Associates obtain an authorization that is signed by the patient. The purpose of obtaining an authorization is to provide the patient with an opportunity to determine how PHI may be used or disclosed, and to inform the patient of rights under HIPAA.

Pursuant to 45 CFR §164.508, I.C. 16-39-2-1, I.C. 16-39-2-11, I.C. 16-39-1-4 as pertains to mental health care records and the Health Insurance Portability and Accountability: If it is necessary for any of my medical records to be discussed or sent to another entity or health care provider for medical reasons and to carry out treatment, payment and healthcare related operations, I authorized Evansville Psychiatric Associates to do so as delineated in this authorization. Any release will always comply with the minimum necessary information necessary to accomplish the required task. This is not a “blanket” or general release. If this authorization does not state a specific individual or entity that is named in subsequent requests, an additional authorization will need to be filled out and signed by the patient.

The following information may be used or disclosed as appropriate: admission notes, initial evaluations, laboratory data, therapist notes, treatment plans, psychological testing, EKG, EEG, radiological data, progress notes, sleep study data, evaluation tools, student behavior checklists for teachers, account history, inpatient summaries, and other chart elements. This information may be communicated on paper, electronically or verbally.

Purposes of Disclosure: Information listed above may be disclosed for the purposes of evaluation, diagnostics and treatment, claims for reimbursement and continuing medical care.

The following persons may communicate and exchange my Protected Health Information (PHI) with each other:

- The clinicians and staff of Evansville Psychiatric Associates, as medically necessary for coordination of care and for treatment reimbursement:

- Dr. John Bambenek
- Pat Easley, LCSW
- Julie Kahre, LCSW
- Radha Tatineni, MD
- Our clerical staff, billing and administrative personnel. All personnel have signed confidentiality agreements.
- Dr. David Holajter
- Leigh Baldwin, APN
- Michael Eatmon, LCSW
- Charlene Moore, LCSW
- Dr. Bruce Hust
- Carol Hastings, LCSW
- Paul Mefford, LCSW

- Pharmacists/pharmacy representatives where I contract to have my local prescriptions filled: (Please provide location and telephone number.)

- CVS: _____
- Target: _____
- Sam’s: _____
- Oak Hill Pharmacy: _____
- Schnuck’s: _____
- Buehler’s: _____
- Walgreen’s: _____
- Wal-Mart: _____
- K-Mart: _____
- Paul’s Pharmacy: _____
- Other: _____
- I use mail order through my insurance.

I otherwise authorize Evansville Psychiatric Associates to obtain pharmacy profiles from any and all necessary pharmacies.

- My Primary Care Physician is: _____
- Other person(s) authorized to speak with my clinician(s) and obtain or release information about me: _____

In signing this, I also authorize the limited release of my medical information as necessary to process any claim I file to persons representing my insurance company, Workman’s Compensation, Social Security, Medicare or Medicaid, or representatives acting on their behalf.

Right to terminate or revoke: You may revoke or terminate this authorization by submitting a written revocation to Evansville Psychiatric Associates. You must submit this revocation in writing to our Privacy Official to terminate this authorization. The act of revocation will not apply to information released before the date of this revocation.

A photographic copy of this authorization may be used in place of the original.

Potential for re-disclosure: Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. While we ask that information not be re-released without your specific permission and we only do business with other organizations who are HIPAA compliant, it may not be possible to ensure your right to privacy of this information once Evansville Psychiatric Associates discloses your information to another party.

Rights of the individual: You may inspect or copy information used or disclosed under this information if deemed safe for you to do so by your clinician(s). Usual fees will apply to copying charges. You may refuse to sign this authorization.

Effect of refusing authorization: If you refuse to fill/sign this authorization, Evansville Psychiatric Associates will not refuse you treatment solely on that matter. This form is voluntary, and you are able to specifically allow or restrict who can use or disclose your protected health information. As a mental health clinic we have long been attuned to the importance of confidentiality and discretion, before the government mandated it be written in this specific language. We do feel that it is important to be able to discuss your case as needed with other clinicians as it benefits your care. We also feel it is imperative to be able to speak with pharmacies and ensure that you will not be experiencing any adverse drug interactions from pharmaceuticals that we are not aware of. If you choose to deny us the ability to speak with your primary care physician or other referring healthcare provider we will respect that, although we feel it is generally in your best interest to have open communication with these individuals.

Do you have any specific restrictions? _____

[Check one of the boxes in the following paragraph. If left unchecked, will last while receiving services.]

Expiration Date: This authorization is effective for: 180 days (6 months) / one year unless revoked or terminated earlier by the patient or the patient’s representative, as long as I continue receiving services from Evansville Psychiatric Associates unless revoked or terminated earlier by the patient or the patient’s representative. An earlier termination may be written here: _____.

By my signature I am acknowledging that I have read and understand this authorization and understand that I may request a copy of this authorization.

Signature of Patient / Parent / Guardian / Legal Representative * Date

Witness ** Date

**Note: If you are a guardian or legal representative, we must have legal documentation on file.*

***If signature is other than the patients, print patient’s name here:* _____