Family Psychiatry Services
Adly Thebaud, MD, PA

Axis I Behavioral Center
Adly Thebaud, MD, PA

Authorization for Release of Confidential Information

PATIENT NAME:	PATIENT DOB:

I hereby authorize Family Psychiatry Services and AXIS I Behavioral Center (collectively, Adly Thebaud, MD, PA) to ☐ REQUEST & OBTAIN ☐ RELEASE / DISCLOSE ☐ EXCHANGE **my medical, psychiatric, alcohol or drug diagnosis information contained in my records from/to/with the following individuals and/or facilities:**

DOCTOR/PRACTICE/INDIVIDUAL(S)	
ADDRESS	
PHONE	FAX

The information covered by this authorization includes:

☐ COMPLETE RECORD ☐ LAB REPORTS ☐ PHYSICIAN NOTES ☐ ADMISSION & DISCHARGE RECORD

☐ CONSULTS / REPORTS ☐ MEDICATION LIST ☐ THERAPY RECORDS ☐ LAST 3 PROGRESS NOTES

☐ OTHER: _____

The information specified above is requested to be released *immediately* for the purpose(s) of:

☐ CONTINUATION OF TREATMENT ☐ COORDINATION OF CARE ☐ INSURANCE

☐ OTHER: _____

I have the right to receive a copy of this authorization. I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization. I understand that information used or disclosed under this authorization may be subject to re-disclosure by the recipient without further protection under HIPAA rules; I understand that I may be charged for copies provided. Incomplete information may cause delay. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law. **This authorization is valid for one year unless otherwise revoked. I give this consent voluntarily.**

SIGNATURE OF PATIENT: (Parent/Guardian/LAR if under 18) (Caregiver/LAR for special populations)	DATE:

A PHOTOSTATIC COPY OF THIS AUTHORIZATION IS TO BE CONSIDERED AS VALID AS THE ORIGINAL.