New Patient Information Form
Please Print or Type

Center of Revitalizing Psychiatry, P.C.
795 Main Street, Hackensack NJ 07601
Phone: (201) 488-5161 Fax: (201) 488-5162

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT NAME:_____ Date of Birth:_____

I authorize Center of Revitalizing Psychiatry (Name of Office) 795 Main Street, Hackensack NJ 07601 (Address)

(201) 488-5161 (Phone Number) (201) 488-5162 (Fax Number) to release my information to / to obtain my information from (Circle One)

_____
(Name of Office or Individual) (Address)

_____/___/_____/___/_____
(Address Cont.) (Phone Number) (Fax Number)

PLEASE CHECK APPROPRIATE INFORMATION TO BE RELEASED:

___Initial Psychiatric Evaluation
___Mental Health Progress Notes
___Psychological Evaluations
___Discharge Summary
___Substance Abuse Records
___Lab Reports
___Financial Information
___Program Participation
___Current Medications
___Verbal Communication
___Entire Record
___Other:_____

THE PURPOSE OF THIS DISCLOSURE:

___Continuity of Care
___Insurance Benefits
___Social Security Benefits
___Legal Reasons
___Personal Reasons
___Other:_____

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1966 (P.L. 104-191), 42 U.S.C. Section 132d, et Seq., and regulation promulgated there under, as amended from time to time (collectively referred to as HIPAA"). This authorization affects your rights in the privacy of your personal behavioral health information. Please read it carefully before signing.

I understand that the information in my health record may include information relating to sexually transmitted disease acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

Center of Revitalizing Psychiatry, P.C. will not condition treatment on your providing authorization for the requested use or disclosure. You may refuse to sign this authorization. You have the right to revoke this authorization, in writing, at any time, except to the extent that Center of Revitalizing Psychiatry, P.C. has taken action in reliance on it.

By signing this authorization I acknowledge and agree that any information used or disclosed pursuant could be at risk of re-disclosure by the recipient and no longer protected under HIPAA. This authorization will expire on _____ (date). If I fail to specify expiration date this authorization will expire one year from the date on which it was signed.

This information has been disclosed to you from record protected by 42 CR Part 2. The Federal Rules prohibit you from making any further disclosure unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFT Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose.

ACKNOWLEDGED AND AGREED TO BY:

_____ _____
Patient / Guardian Signature Date

_____ _____
Witness Signature Date