NeuroPsychiatry Center - Ravi Kant, MD, P.C.
300 Old Pond Road, Suite 201, Bridgeville, PA 15017
Tel. # 412-220-7323 Fax # 412-220-7325

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name:_____ **Date of Birth:**_____

I consent to and authorize to disclose my protected health information relating to my identity, diagnoses, prognosis, and/or treatment. These records may include information related to medical conditions, tests, mental or behavioral health, substance abuse (drug and alcohol), and HIV-related. These records are called protected health information and are protected by federal and/or state laws.

From:_____
(Name and address of provider or facility releasing records)

To: ☐ PCP ☐ Family Member ☐ Therapist ☐ Other_____

Name: _____

Address: _____

Phone Number:_____ **Fax Number:** _____

The purpose for this disclosure is: ☐ Coordination of Care ☐ Notify PCP of First Appt ☐ Other_____

I understand that the specific types of records to be released (identify all records or all that apply) are:

☐ All records including psychiatric/psychological evaluation ☐ Insurance claims and payments only

☐ Other_____

****Mental or behavioral health, substance abuse, and HIV-related information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated.****

DO NOT RELEASE: ☐ Mental/Behavioral Health ☐ HIV-Related ☐ Substance Abuse (Drug and Alcohol)

I understand that this authorization is revocable upon my written request and that this consent will remain in force unless revoked in writing by the patient or legal guardian. I also understand that my decision to revoke this authorization may result in my insurance company not being able to pay for my medical care and I will be liable for payment for the services rendered.

Patient Signature _____ **Date** _____
(If patient is a minor (ages 14-18) he/she must sign this Authorization for Release of Protected Health Information Form)

Print Name _____

Responsible Party Signature _____ **Date** _____
(Parent/Guardian/Legal Representative)

Print Name _____**Relationship to Patient** _____
(Guardian/Legal Representative may be required to attach supporting legal documentation)