Authorization for Release of Information

Ravi Kant MD PC

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Patient Name _____ **Date of Birth** _____

I consent to and authorize to disclose 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. Please note that if the patient is 14 year or older a signed release by the patient is required to share information with the patient's parents or legal guardians.
(One form is required for each recipient)

Please release my medical information to the following:

☐ **From** ☐ **To: Ravi Kant, MD, PC/NeuroPsychiatry Center**

☐ To ☐ From: ☐ PCP ☐ Family Member ☐ Therapist ☐ Other: _____

Name: _____

Phone Number_____ Fax Number _____

E-mail Address _____

The purpose of this disclosure is: ☐ Coordination of care ☐ Notify PCP of first appt

☐ FMLA/Disability ☐ 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

☐ Appointments and Refills Only

<u>*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. *</u>

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.

(If the patient is a minor (ages 14-18) he/she must sign this Authorization for Release of Protected Health Information)

Patient/Guardian Name _____

Relationship _____

Signature _____ Date _____