Form 4.1-12008

Ellison & Associates of Raleigh, P.C.
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AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient Name: _________________________________ DOB: ____________________

Date(s) of Treatment ____________________________ SSN #:___________________

I HEREBY FREELY AND VOLUNTARILY AUTHORIZE ELLISON & ASSOCIATES TO:
_____RELEASE/DISCLOSE MY PROTECTED HEALTH INFORMATION TO:
______OBTAIN MY PROTECTED HEALTH INORMATION FROM:

(Individual, Organization, or Facility) (Phone Number)

(Address) (Fax Number)

(City, State, Zip Code)

Circle or explain other reason for this disclosure: Medical treatment Insurance purposes

Educational placement Legal reasons Progress updates Continued treatment To the Patient

Discharge planning Other____

Circle or explain information to be used or disclosed:

Psychiatric evaluation Progress report Medication records Physician's Orders

Lab/X-ray results History & physical Medical consultations

Psychological testing Psychosocial assessment Discharge summary Aftercare plan

_____Clinic notes (dates)____

_____Other:____

I understand that my medical records may contain information regarding testing, drug, and/or alcohol diagnosis and treatment, a communicable or venereal disease that may include but not be limited to AIDS and/or tuberculosis. I understand that such information is confidential and protected by federal law. I understand that the provision of health care treatment to me cannot be conditioned upon my agreement to sign an authorization for the disclosure or use of my health information for purposes other than for treatment, payment and healthcare operations. I understand that the potential exists for health information that is released with my authorization to be re-disclosed by the recipient, and to be no longer protected by federal HIPAA law. I understand that I have the right to revoke this authorization at any time by giving written notice to the Ellison & Associates Privacy Officer, except to the extent that action has already been taken in reliance on it. **This authorization will expire 180 days following signature** unless another date or condition is specified. Other date or condition: 1 year. **~~ SIGNATURE BELOW ~~**

Patient ____ **Date**________________

Guardian/Representative________________________________ **Date**________________

Relationship to Patient __________________________