RE:

Authorization For Disclosure Of Protected Health Information

By Fort Wayne Psychiatry PC, 2414 East State Blvd. #301, Fort Wayne, IN 46805

1. I authorize Fort Wayne Psychiatry, PC and its staff to make the authorized use and/or disclosure of my protected health information.

2. My authorization applies to the information described below. Only this information may be used and/or disclosed pursuant to this authorization: ____

3. I authorize the following persons (or class of persons) to receive my protected health information:
____

____

4. I understand that, if my protected health information is disclosed to someone who is not required to comply with the federal privacy protection regulations, then such information may be re-disclosed and would no longer be protected.

5. I understand that I have a right to revoke this authorization at any time. My revocation must be in writing in a letter. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my protected health information have acted in reliance upon this authorization.

6. This authorization expires upon (*insert date or an event that triggers Expiration*):____

7. I understand that I do not have to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment from Fort Wayne Psychiatry, PC nor will it affect my eligibility for benefits.

8. My protected health information will be used or disclosed upon request for the following purposes (please name and explain each purpose):
____

9. I understand that I have a right to inspect and copy my own protected health information to be used or disclosed (in accordance with the requirements of the federal privacy protection regulations found under 45 C.F.R. §164.524).

10. I understand that Fort Wayne Psychiatry, PC will/ will not receive compensation for its use and/or disclosure of my protected health information.

I certify that I have received a copy of the authorization.

____________________________________	____________________________________
Signature	Date
____________________________________	
Name	
____________________________________	____________________________________
Name of Personal Representative	Relationship to Patient