DEPARTMENT OF PSYCHIATRY & BEHAVIORAL MEDICINE
3515 E. FLETCHER AVENUE, TAMPA, FLORIDA 33613 TEL. (813) 974-8900 FAX (813) 974-3223

***AUTHORIZATION FOR THE RELEASE***
***OF PSYCHIATRIC AND/OR PSYCHOLOGICAL INFORMATION***

I_________________________________________________, DOB_______________ S.S.#______________________)
by signing this form I understand that I am authorizing the designated medical records custodians or database custodians listed below to disclose/release my Protected Health Information including psychiatry/psychological and/or Substance Abuse Information contained in my records as defined under 45 CFR 160-164, the federal regulations implementing the Health Insurance Portability and Accountability Act of 1996 ("HIPAA")

Name of person(s) or organization(s)______________________________________________________

Street address:_________________________________________________________________________

City, State and zip code__________________________________________________________________

Telephone No.:__________________________________Fax No. ______________________________

***TO:***
*THE USF DEPT. OF PSYCHIATRY, USF PSYCHIATRY CLINIC FOR THE FOLLOWING USE :*

___________________________________________________________________________________________

By initialing below, I specifically authorize the use and disclosure of the following PHI:
*(Please provide a detailed description of the particular data and period of time you are requesting)*

____Initial evaluation (Diagnostic Interview) ______________________________________________

____Follow up notes_________________________________________________________________________

____Medication notes________________________________________________________________________

____Psychological tests_____________________________________________________________________

____Verbal reports__________________________________________________________________________

____Billing records_________________________________________________________________________

____Clinic/outpatient records_______________________________________________________________

____Laboratory reports______________________________________________________________________

____Pathology reports_______________________________________________________________________

____Radiology reports_______________________________________________________________________

____Consultation reports____________________________________________________________________

____Other___________________________________________________________________________________

OVER ➔

The information to be used or disclosed pursuant to this authorization form may include information relating to: psychiatric or psychological care, including psychotherapy session notes as defined in 45 CFR 164. 501. If I am the patient requesting my own psychiatric/psychological treatment records, I understand that I may review a report of examination and treatment instead of copies of the psychiatric/psychological records.

You may revoke this authorization form at any time by notifying the records custodian of my intent to revoke this authorization. Returning this form to the records custodian, signed, dated and with the words "authorization revoked" is sufficient notice. However, you understand that such revocation will not have any effect on any information already used or disclosed to the University of South Florida before the University received written notice of revocation.

I understand that I am not required to sign this Authorization form in exchange for the patient receiving treatment from the University of South Florida or ___________________________________. I also understand that payment, enrollment in a health plan and/or eligibility for benefits will not be conditioned upon my signing this form.

**This authorization form *expires* on __________________or when ___________________occurs, but not later than <u>one year from the date of signature below</u> .**

I understand that I may refuse to sign this form.

_____________________________________________ _____________________________

Signature of patient or personal representative Date

________________________________________________ ______________________________________

Printed name of patient or personal representative (circle one) Relationship to patient granting authority to act for patient

____________________________________ ____________________________ __________________

Witness Signature Printed Name Date

Copy given to Signor___________