GRAYSON & ASSOCIATES, P.C.

RELEASE OF INFORMATION

Please fill this form out ***completely.***

Missing or inaccurate information may result in processing delays.

PATIENT NAME: _____ **DOB:** _____

I, _____, hereby authorize Grayson & Associates, P.C. to release to:
Patient Name

_____ _____
Agency or Individual phone number

We will mail your records to the address completed below.

No medical records will be faxed.

_____
Mailing/Street Address (Street Address MUST INCLUDE street number. Also include suite number where applicable)

_____ _____ _____
City **State** **Postal Code**

The above named patient's Protected Health Information to be mailed to the address provided above:

_____ all medical records _____ all financial records

_____ the following records _____
(Specify exactly what is needed: Example: diagnosis and treatment letter, medication list, etc)

_____ consent for _____, _____ to communicate
Agency or Individual Relationship to patient

with _____ at Grayson & Associates. **I understand that no records will be sent**.
Specify doctor, nurse, therapist.

I understand that the records described above may contain information relating to sexually transmitted disease, HIV/AIDS, notifiable diseases, alcohol and drug abuse treatment and/or mental health, and I specifically authorize the release of this information.

Patient or Personal Representative Signature:_____ **Date:** _____

Relationship to patient if signed by Personal Representative: _____

The Protected Health Information described above is to be released for the following purposes:

_____
(Life Insurance, Disability, at request of patient or parent, etc.)

I understand that the information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that Grayson & Associates, P.C. cannot condition treatment, payment, enrollment or eligibility of benefits on the signing of this authorization. I understand that I may revoke this authorization by sending written notice to Grayson & Associates, P.C. at the address checked off below. However, I understand that any revocation will not be effective as to any action taken in reliance of the authorization prior to receipt of the written revocation.

This authorization will expire on the following: (Please circle one) Date_____ One time only
(No longer than one year from date signed)

Patient or Personal Representative Signature: _____ **Date:** _____

Relationship to patient if signed by Personal Representative: _____

OFFICE USE ONLY

PT ACCT # _____

DATE ROI RECEIVED

_____
RECEIVED BY

_____

PROCESSING NOTES
CLINICIAN APPROVALS, CALLS MADE, FAXES SENT, ETC.

DATE INVOICED (WHERE APPLICABLE)

_____
INVOICED BY

_____
DATE PMT NOTICE RECEIVED

_____

NOTICE TO RECIPIENT OF INFORMATION PROTECTED BY 42 C.F.R. PART 2

This notice accompanies a disclosure of information concerning a patient in alcohol or drug treatment, made to you by the consent of such patient. This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.