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AUTHORIZATION TO RECEIVE OR DISCLOSE PRIVATE HEALTH INFORMATION (PHI)

Patient name: _____ Date of Birth: ____/_____/_____

I hereby authorize the following individual:

Doctor/Therapist, Clinic Name:_____

Phone: _____-_____-_____ Fax: _____-_____-_____

To receive and/or disclose the specific health and medical information described below:
☐ Any applicable medical and/or psychiatric records
☐ Only records during the period from _____/_____/_____ to _____/_____/_____
☐ Other: _____

This information should be received from and/or disclosed to Dr. Sean P. Heffernan for the purpose of (check all that apply):
☐ Continuity of care ☐ Coordination of care
☐ Other: _____

I have reviewed and understand this Authorization. I also understand that the information received or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected under federal law.

Patient/Guardian: _____ Date: _____/_____/_____

Witness: _____ Date: _____/_____/_____

Notice: I cannot make receipt of this signed Authorization a condition of treatment. You may inspect a copy of the protected health information in question, you may refuse to sign this Authorization, and I must provide you with a copy of the Authorization if you request one. You have the right to revoke this Authorization at any time, provided that you do so in writing, except to the extent that I have already received or disclosed the information relying on this Authorization. Unless otherwise specified, this Authorization will expire when transfer of care is complete.