HOUSTON ADULT PSYCHIATRY
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TEL: 832-384-1560
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Frank Chen, MD PA **Michael Barber, MD PA**

CONSENT TO OBTAIN OR RELEASE CONFIDENTIAL INFORMATION

I, _____ DOB _____/_____/_____
(Patient's Full Name) *(Patient's DOB)*

Hereby authorize the following provider(s) and respective employees of Houston Adult Psychiatry to obtain or disclose my Personal Health Information (PHI) to/from the designee identified below.

☐ **Release to** ☐ **Obtain from:** ☐ **PROVIDER/OFFICE**
☐ **INDIVIDUAL (Relationship)** _____

Name:_____

Street Address:_____

City: _____ State:_____ Zip:_____

Telephone: (_____) - _____ Fax: (_____) - _____

☐ **ALL RECORDS (includes all of the following)** or
☐ Lab Results ☐ Progress Notes ☐ Dr.'s Orders ☐ Appointment Dates & Time
☐ Medication List ☐ Verbal Communication

FOR THE PURPOSE OF:

☐ Legal Documentation ☐ Continuation of Care ☐ Transfer of Care ☐ Personal Use

The authorization may include disclosure of Information relating to Alcohol, Drug Abuse, Sexually Transmitted disease, Mental Health Treatment and Confidential Acquired AIDS or HIV related information by initialing the line below. I specifically authorize release of such information to the person indicated above.

Initial _____ **Date**_____/_____/_____

I, the undersigned, understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it and that in any event this consent shall expire 180 days after the date the patient discharge unless another date is specified.
Specification of the date, event, or condition upon which this consent expires: _____/_____/_____

TO THE PARTY RECEIVING THIS INFORMATION: This information has been disclosed to you from records whose confidentiality may be protected by federal law. If so, federal law regulations (42CFR, Part 2) prohibits you from making any further disclosure of it without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. (FOR PATIENT RECORDS APPLICABLE UNDER FEDERAL LAW 42 CFR, PART 2)

_____ _____/____/_____
Signature of Patient Date

_____ _____/____/_____
Parent / Guardian / Authorized Representative Signature (If applicable) Date

_____ _____/____/_____
Signature of Witness Date