Authorization to Exchange My Health Information

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910.763.3034 -- fax 910.251.7859

Patient name: _____ Date of birth: _____

This authorization allows Lori Birdsong, MD, to exchange health information with:

Name (or title) and organization: _____

Address: _____ City:_____

State: _____ Zip: _____ Phone: _____Fax: _____

I. My Authorization

This form, when completed and signed by you, authorizes the mutual exchange of protected health information from your clinical record to the person you designate. I authorize my psychiatrist, Lori Birdsong, MD, and/or her administrative staff to disclose the following health care information (check all that apply):

- ❑ All of my health information for the date(s) _____ through _____
- ❑ My health information relating to the following treatment or conditions:
  - ☐ *psychiatric records*
  - ☐ *radiological studies*
  - ☐ *alcohol abuse treatment information*
  - ☐ *Sexually transmitted disease information*
  - ☐ *laboratory data*
  - ☐ *drug abuse treatment information*
  - ☐ *HIV / AIDS information*
  - ☐ *Other*:_____

I authorize this exchange for the following reasons (check all that apply):

☐ Individual request ☐ Continuity/Coordination of care ☐ Other: _____

This authorization ends:

☐ On (date) _____ ☐ When the following event occurs: _____

II. My Rights

I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, or enrollment). However, I do have to sign an authorization form:

- To take part in a research study, or
- To receive health care when the purpose is to create health information for a third party.

I may revoke this authorization in writing, except to the extent that information or action has already been taken by Lori Birdsong, MD based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are to:

- Fill out a revocation form. The form is available from the office, or
- Write a letter to the office.

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____ _____ _____

Patient or legally authorized individual signature Date Time

_____ _____

Printed Name if signed on behalf of patient Relationship (parent, legal guardian, personal representative, etc.)