Talkiatry

Phone: 833-351-8255
Fax: 888-815-3583
hello@talkiatry.com

109 W 27th Street Suite 5S,
New York, NY 10001

Authorization to release medical information pursuant to HIPAA

Use this form if you would like Talkiatry to disclose your protected health information (PHI)/medical records to yourself, another person, or another entity.

Please complete all details in this form, sign it, and return to Talkiatry via:

- Email to medicalrecords@talkiatry.com (*preferred*)
- Mail to Talkiatry, Medical Records Dept., 109 W 27th St, Suite 5S, New York NY 10001
- Fax to 1-888-815-3583

Patient details

Name _____ Date of birth _____

Address _____ State _____ Zip Code _____

Email address _____

Parent or legal guardian of patient (if applicable)

Name _____ Date of birth _____

Address _____ State _____ Zip Code _____

Email address _____

By completing, signing and submitting this form, I request and authorize Talkiatry, represented by MCCD Psychiatry Services PLLC and all members of its affiliated covered entity (collectively "MCCD Psychiatry Services") to disclose my protected health information, in verbal or written form, to the following individual or third party for the purpose specified in this authorization.

Person/entity to release PHI to

(If you are requesting your records to be sent directly to you, fill out your own details here)

Individual Name (if applicable) _____

Institution name (if applicable) _____

Address _____ State _____ Zip Code _____

Phone _____ Fax _____ Email address _____

Methods of transmission of PHI

Please check the method you would like Talkiatry to release PHI:

- [x] Email transmission of PHI
- [ ] Fax transmission of PHI
- [ ] Verbal exchange of PHI
- [ ] Mailed hard copies of PHI*

** Note that there is a patient-associated cost for providing mailed hard copy records. This cost will vary by state and the number of pages of records being supplied. An estimate will be forwarded and must be paid before hard copy records can be sent.*

Purpose of release

- [ ] Patient's own use
- [ ] Continuity of care
- [ ] Social security/ Disability claim
- [ ] Insurance claim
- [ ] Legal proceedings
- [ ] Other (please specify): _____

Protected health information to be released

I authorize the following information to be released:

- [x] Entire health record, including patient histories, progress notes, test results, referrals, consults, insurance records and the sensitive information listed below, **for all dates of service.**

OR

- [ ] Entire health record, including patient histories, progress notes, test results, referrals, consults, insurance records and the sensitive information listed below, **for only the following date range:**

Start date: _____

End date: _____

OR

- [ ] Other (please specify) _____

Sensitive information:
Please **uncheck** the box next to any sensitive material you **do not** wish to be released:

- [x] Substance abuse, diagnosis or treatment
- [x] Mental health information, including psychiatric clinical records
- [x] HIV/AIDS testing, status, diagnosis and treatment
- [x] STI testing, diagnosis or treatment
- [x] Genetic testing information
- [x] Biometric information
- [x] Reproductive or sexual health application information
- [x] Billing records

Expiration of authorization

This authorization is valid and will expire **one year** after the date of signing, **unless formally withdrawn earlier by the patient**.

Withdrawal of authorization

This authorization may be withdrawn at any time by submitting a written request to Talkiatry. Withdrawal of this request will not affect any authorized action taken place prior to receipt of a written request to withdraw authorization.

Signature and authorization

PHI released may contain sensitive information as authorized above. Talkiatry, MCCD Psychiatry Services and many other organizations and individuals such as doctors, healthcare facilities and health insurance plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to an individual or entity who is not legally required to keep it confidential, it may no longer by protected by state or federal confidentiality laws.

I have read and understand the information in this authorization.

Signature of patient or authorized representative (signed or typed) _____ Date _____

If signed by authorized representative, relationship to patient: _____

Printed name of authorized representative _____