

Authorization to obtain medical information pursuant to HIPAA



Use this form if you would like an external healthcare provider to disclose your protected health information (PHI)/medical records to Talkiatry for the purposes of continuity of care. This is allowing Talkiatry to have access to your protected health information (PHI)/medical records from another healthcare entity outside of Talkiatry.

Please complete all details in this form, sign it, and provide it to Talkiatry and to your non-Talkiatry healthcare provider. Your Talkiatry clinician will reach out to the external healthcare provider indicated in this form.

(Please note some healthcare providers or facilities require a fee in order to release medical records. This fee, if applicable, will be the patient's responsibility to the extent permitted by law).

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 the below person/entity to release my protected health information to Talkiatry, represented by MCCC Psychiatry Services PLLC, and all members of its affiliated covered entity (collectively "MCCC Psychiatry Services") for the purposes of continuity of care.

Person/entity to release PHI to Talkiatry

Individual Name (if applicable) _____		
Institution name (if applicable) _____		
Address _____	State _____	Zip Code _____
Phone _____	Fax _____	Email address _____

Methods of transmission of PHI

Verbal exchange of PHI

Email transmission of PHI (*send to hello@talkiatry.com*)

Fax transmission of PHI (*fax to 888-815-3583*)

Mailed hard copies of PHI (*mail to Talkiatry, Medical Records Dept., 109 W 27th St, Suite 5S, New York NY 10001*)

Note to external healthcare provider disclosing

PHI to Talkiatry: Please only supply records via phone call, email, fax or mailed hard copy. Please **DO NOT** supply electronic records on external media (CD, DVD, USB thumb drive, etc). Any records received on such media cannot be accessed and will be returned.

Protected health information to be released

I authorize the following information to be released:

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:

Substance abuse, diagnosis or treatment

Mental health information, including psychiatric clinical records

HIV/AIDS testing, status, diagnosis and treatment

STI testing, diagnosis or treatment

Genetic testing information

Biometric information

Reproductive or sexual health application information

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 the person or entity releasing PHI. Withdrawal of this request may 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, MCCC 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 be protected by state or federal confidentiality laws. I understand that treatment by any party may not be conditioned upon my signing of this authorization. **I have read and understand the information in this authorization.**

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

If signed by authorized representative, relationship to patient: _____

Date _____

Printed name of authorized representative _____