Nicole Brynes, DNP
195 Crowe Avenue
Mars, PA 16046

AUTHORIZATION AND CONSENT TO USE & DISCLOSE HEALTH INFORMATION

Patient Name_____

DOB: _____ Phone: _____

Address: _____
_____

I hereby authorize: (Name) _____
(Address) _____
(Address) _____
(Phone/Fax) _____

To release/ exchange information with: Nicole Brynes, DNP_____
195 Crowe Avenue Mars, PA 16046
Fax#: 724-625-4949 _____

The information to be released was gathered from the onset of services to present OR
dates: _____ to _____ and include:

- ☐ Reason for referral/Diagnosis
- ☐ Medical History
- ☐ Discharge Summary
- ☐ Psychological Testing
- ☐ Summary of Treatment, verbal or written
- ☐ Psychiatric/Behavioral Health Evaluation
- ☐ School Records
- ☐ Labs/Diagnostic Tests
- ☐ Other (Specify) _____

The above specified information is requested for the following purposes only:

- ☐ Continuity of Care
- ☐ Disability Determination
- ☐ Other (Specify)
- ☐ Treatment Planning
- ☐ Legal Proceedings
- ☐ Liaison with referral source
- ☐ Follow-up Services

_____

I have been told that to protect the limited confidentiality of records, my agreement to obtain or release information is necessary and that this permission is limited for the purposes and to the persons listed above, and will be effective during the dates below. I will be told the name, to whom, and the dates when the information will be sent, and that I may withdraw my permission at any time. This right and my other rights are contained within the Notice of Privacy Practices. I acknowledge and understand that treatment is not conditioned upon my signing of this authorization. I understand that information disclosed pursuant to this authorization may be subjected to re-disclosure by the recipient and no longer protected by the HIPAA Privacy Rule. I understand that I may ask to see information that is sent. I also understand that the information to be released will include HIV-related information and drug and alcohol-related information if contained in these records.

This consent will expire one year from the date of consent, unless otherwise specified _____
(Date)

Having signed this release of information, I acknowledge that I have read this form in full or have had it explained in full to me. I further acknowledge my understanding of it, and I certify that my consent has been given freely, voluntarily, and without coercion.

_____
(Signature of Patient or Guardian) (Date Signed)

_____
(Witness) (Date Signed)