GENPSYCH
Mental Health of the Future

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Client's Name: _____ **DOB:** _____

I, _____, request and authorize GenPsych PC to release confidential health information protected by U.S. Federal and State privacy laws to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____ Fax Number: _____

Purpose of release:_____

This request and authorization applies to: **(check all applicable)**

_____ Psychiatric Evaluation _____ Therapy Notes _____ Treatment Plan(s)

_____ Substance Abuse Evaluation _____ Substance Abuse Treatment Information

_____ Medication Logs _____ Toxicology Results _____HIV/AIDS Information

_____ Other _____ *(please specify the documents)*

_____ *** Marketing purposes (please define the type of information that may be released and how it may be used)

_____

*** 'Marketing is defined as "any communication about the organization, its products or services that encourages recipients to purchase or use the product or service."

*** GenPsych, its employees and patients are strictly prohibited from receiving any renumeration by GenPsych or its affiliates as a direct result of this release However, the release of protected health information for marketing purposes may encourage recipients' use of the organization's products or services.

****Pursuant to NJAC 13:35-6.5, Genpsych reserves the right to charge $1.00 per page for medical record reproduction or $100.00 for the entire record, whichever is less. If the record requested is less than 10 pages, the cost for the record reproduction may be up to $10.00 to cover postage and the miscellaneous costs associated with the record retrieval.

I understand and authorize the exchange of information as requested above. I also understand that this request will remain in effect until _____ or until I am discharged from GenPsych PC.

I understand that I may revoke this authorization in writing, which will take effect on the date it is received, except to the extent that GenPsych has already taken action in reliance upon my authorization, or as set forth by GenPsych's Notice of Privacy Practices.

I understand that if the above named person or entity is not a health care provider or part of a health plan covered by federal privacy regulations and this form authorizes the release of my health information, **my health information may be re-disclosed** by the person or entity I have named above and will no longer be protected by these regulations. However, the person or entity named above may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I understand that if I refuse to sign this form, GenPsych will not disclose my information to the person or entity named above, unless otherwise required by law. Furthermore, I understand that GenPsych will not condition any treatment or services upon my signing this form.

Client Signature: _____ Dated: _____

Legal Rep's Signature*: _____ Relationship to Client:_____ Dated:_____

*** If Client is aged 14-17, both client and legal representative must sign release form**