pep
Holistic Psychiatry & Wellness

AUTHORIZATION TO USE/DISCLOSE MEDICAL INFORMATION

Patient name: _____ Date of Birth: _____

Patient Address and Phone Number: _____

_____

PEP Holistic Psychiatry & Wellness, the office of Dr. Janiece C. Andrews, is authorized to

release and receive information from: _____
(agency/individual name)

_____
(address, phone number & fax number **required**)

Description of Information to be Released

Clinical Summary	Yes ❑	No ❑	Initials _____
Psychological Test Results	Yes ❑	No ❑	Initials _____
Discharge Summary of any Hospitalizations	Yes ❑	No ❑	Initials _____
Current Report Card (if applicable)	Yes ❑	No ❑	Initials _____
Physical Examination	Yes ❑	No ❑	Initials _____
Psychiatric Evaluation	Yes ❑	No ❑	Initials _____
Records of Psychiatric Outpatient Treatment	Yes ❑	No ❑	Initials _____
All Lab Studies from the last 24 months	Yes ❑	No ❑	Initials _____
Educational Assessments	Yes ❑	No ❑	Initials _____
Probation Records	Yes ❑	No ❑	Initials _____
Substance abuse records (drug or alcohol)	Yes ❑	No ❑	Initials _____
HIV/AIDS related information	Yes ❑	No ❑	Initials _____

Other:_____

_____

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Purpose for the Disclosure

I am requesting use or disclosure of protected health information for the following purpose(s):

PLEASE CHECK ALL THAT APPLY

- ❑ Continued Medical Care
- ❑ Insurance
- ❑ Changing Physicians
- ❑ Legal
- ❑ Other: _____

Authorization

I have read and understand this authorization, and I authorize the use or disclosure of protected health information as described in this authorization.

_____ _____

signature of patient or personal representative date

_____ _____

printed name of personal representative (if applicable) relationship to patient

All information obtained or released will be handled confidentially, in compliance with the **Federal Privacy Act (PL 92-282)** and the **Pennsylvania Mental Health Procedures Act.** I understand that my agreement to obtain or release information is necessary, and that this permission is limited for the purpose, and the persons listed above. I also understand that I may withdraw my permission at any time.