Elessar Psychiatry, PLLC
169 W 2710 S Circle Ste 202a
St George, UT 84790
admin@elessar.care
Cell 720.664.9877 | Fax 888.350.9528

Authorization for Disclosure of Protected Health Information (PHI)

PLEASE FILL OUT ALL SECTIONS

Patient Access Information

• I will provide a picture ID prior to accessing my medical record.
• I may review my medical record without a charge. If I request copies of my medical record, I may be charged a fee.
• I will refer my questions regarding treatment, prognosis, or other clinical matters to my physician.
• If I am involved in a research study involving medical treatment, my access to the research study content may be suspended for as long as the research is in progress. At completion of the research, access to my medical record will be reinstated.

I Understand That

• The information to be disclosed may include a diagnosis or reference to the following conditions: behavioral health services/ psychiatric care; sickle cell anemia; genetic testing; acquired immune deficiency syndrome (AIDS) or human immunodeficiency virus (HIV); or drug and/or alcohol abuse.
• Without my express revocation, this authorization will automatically expire 365 days from the date signed below.
• I may revoke this authorization in writing at any time, except to the extent that action has already been taken to comply with it. I understand that any revocation of consent will not apply to information previously disclosed in accordance with this authorization.
• Information disclosed pursuant to the authorization may be subject to redisclosure by the recipient and is no longer protected by the HIPAA Privacy rule, unless the disclosure includes records from a federally-assisted program specifically providing diagnosis, treatment or referral for treatment of drug and alcohol abuse, in which case redisclosure is prohibited under 42 CFR Part 2.

I would like copies of my medical records released to:

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Patient Information

Full Name_____ Date of Birth_____

Maiden or Other Names Used _____

Address_____

Day Phone_____ Cell Phone_____ City_____

State _____ Zip_____

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Release From

Person/Company/Organization Name _____

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

Email _____

Purpose

- ☐ Continuity of Care
- ☐ Insurance/WC
- ☐ Legal/Law Enforcement
- ☐ Personal
- **X** 2 Way Communication

Date(s) Of Information To Be Disclosed

- ◯ From: _____ Through: _____
- ◯ ALL DATES OF SERVICE

Type of Information to be Released*

- ☐ Visit Notes / Therapy Notes
- ☐ Lab Results
- ☐ Treatment Plans
- ☐ Medication Lists / Medication History
- ☐ Documents from other Providers
- ☐ Billing Record
- ☐ Consultation
- ☐ Appointment Information
- ☐ Complete Registration
- ☐ Schedule, Change, or Cancel my Appointments
- ☐ Pick up Prescriptions and/or Paperwork

Disclosure Format

I would like copies of the items checked above in the following format (Paper–US Mail is default if not marked).

- ◯ Paper – US Mail
- ◯ Fax (healthcare provider only)
- ◯ Email
- ◯ Verbal Only

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My signature is required to validate this authorization. If I do not sign this authorization, this Care Site will still provide treatment and seek payment for services provided. According to State Statutes, this Care Site may charge for copies of medical records.

_____

Patient/Guardian/Personal Representative's **Signature** Relationship (if not patient) Date

_____

Guardian/Personal Representative's **PRINTED** Name, Address, Phone

Return Completed Form to:

Email: admin@elessar.care
Fax: 888.350.9528

Mail: Medical Records
169 W 2710 S Circle, Ste 20a, St George, UT 84790