NPI Established 1970
The Neuropsychiatric Institute

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Failure to provide all information may invalidate this authorization

This authorization may be used to permit a covered entity (as such term is defined by HIPAA and applicable Florida Law) to use or disclose an individual's protected health information. Individuals completing this form should read the form in its entirety before signing and completing all the sections that apply to their decisions relating to the use or disclosure of their protected health information.

Authorization for copies of mental health records:

☐ Electronic via Patient Portal ☐ Fax number listed below
☐ Call requester when records are ready for pick-up with amount of copying fee
☐ Other (NOT email address) Only Electronic means is via Patient Portal _____

Patient Information:

Patient Name (first, middle, last) (please print): _____

Date of Birth: _____ Phone: (_____)_____

Street Address: _____

City:_____ State:_____ Zip Code:_____

Information to be Released from:

Neuropsychiatric Institute, LLC
4107 W. Spruce Street, Suite 100; Tampa, FL 33607
Phone: (813) 636-8811 Fax: (813) 636-8855

Information to be Released to:

Person/Organization: _____

Relationship to Patient (if any): _____

Street Address: _____

City:_____ State:_____ Zip Code:_____

Phone: (_____)_____ Fax: *(preferred)* (_____)_____

SPECIFIC INFORMATION TO RELEASE:

***** *CHOOSE ONLY ONE PLEASE***

☐ **Summary of Treatment** – 1 Page letter to include beginning/ending dates, diagnoses, and current medications

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☐ **Medical Records** ☐ entire chart
☐ Treatment Dates: from _____ to _____

PATIENT NAME: _____

_____

For the following purpose:

☐ Personal Use
☐ Legal Purposes
☐ School
☐ Other (Specify): _____
☐ Treatment/Continuing Medical Care
☐ Disability Determination
☐ Employment

Include: (Indicate by Initialing)

_____ Drug, Alcohol and/or Substance Abuse Records
_____ HIV/AIDS-Related Information (Including HIV/AIDS Test Results)
_____ Genetic Information (Including Genetic Test Results)

The individual signing this form agrees and acknowledges as follows:

(i) Voluntary Authorization: This authorization is voluntary. Treatment, payment, enrollment, or eligibility for benefits (as applicable) will not be conditioned upon my signing of this authorization form.

(ii) Expiration Date of this Authorization: If left blank, will be 1 (one) year from date signed **OR**:
Month: _____ Day: _____ Year: _____

(iii) Right to Revoke: I understand that I have the right to revoke this authorization at any time by writing to the health care provider or health care entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.

(iv) Special Information: By placing my initials on the lines above, I specifically authorize the release of DRUG, ALCOHOL, and SUBSTANCE ABUSE, MENTAL HEALTH INFORMATION, except psychotherapy notes, CONFIDENTIAL HIV/AIDS-RELATED INFORMATION, and GENETIC INFORMATION to the person or entity indicated herein.

(v) Signature Authorization: I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop the disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURES:
If someone other than patient is signing form, please include copy of driver's license with request.

Patient/Legal Representative: _____ Date: _____
(Signature must be handwritten)

If other than Patient, please print Name: _____

Relationship to Patient: _____

Witnessed by: _____ Date: _____

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This form can be scanned and emailed to our secure Patient Portal. *Please call the office to request an invitation*. More information can be found at our website: www.neuropsychiatric.net

Rev.02/2023