Cornerstone Psychiatric Services, Inc.
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1790 E. Venice Ave. Ste. 204 Venice, FL 34292
Phone: (941) 488-8884 **Fax: (941) 375-0119**

Authorization for Use or Disclosure of Protected Health Information

Patient's Name				**Date of Birth** / /	CPS Acct #
Patient Address	City	State	Zip	Telephone Number ( ) -	

I, the patient named above, hereby authorize **Cornerstone Psychiatric Services, Inc.**, to **release to** and/or **obtain from** contact name listed below, in any form or format, my protected health information/records, which may include treatment of drug abuse, child abuse, AIDS, alcoholism or mental illness. This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996, 42 U.S.C Section 132d, and regulations promulgated thereunder, as amended from time to time (collectively referred to as "HIPAA").

□ **To** □ **From (please check one or both) Person or Facility Name:**_____
This is my: □ Primary Care Physician (PCP) □ Mental Health Provider □ Neurologist □ Caregiver □ Parent □ Spouse □ Self □ Other

Address:		
City:	State:	Zip:
Phone:	Fax:	

PURPOSE OF DISCLOSURE (please check one) □ Continuity of Care and/or Coordination of Care □ Disability □ Legal
□ Other_____

INFORMATION TO BE DISCLOSED (please check one or more from the check boxes below)

Service Dates requested: √ **As stated in the requested abstract below, unless specified here:**
Specific Date range: From_____To_____.

□ HOSPITAL Abstract (**most recent stay**)—*includes, as applicable, Discharge Summary, Discharge Medication List, History & Physical, Operative/Procedure Report(s), Consultation Report(s), and lab/other test result(s)*

□ MENTAL HEALTH Abstract—*includes **Initial** Evaluation, **last three** office progress notes/psychotherapy notes, most recent lab results and medication list; additional records may be released/requested after this initial request up until this Release of Information "ROI" expires.*

□ Laboratory Results **(most recent only)**; additional lab results may be requested after this initial request up until this ROI expires.

□ PCP/CLINIC Abstract—*includes, as applicable, **MOST RECENT OFFICE VISIT ONLY,** Summary Lists, Medication Lists, and lab/other test result(s); Additional records may be requested after initial request up until this ROI expires.*

□ Complete record for all dates of service until ROI expires. □ Verbal Communication as needed until ROI expires.

□ Discharge Summary with medication list □ Genetic Testing results □ Last Progress Note only □ Psychological Testing Report.

□ Other: (please provide details):_____

I understand that disclosure of the information in this medical record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information relating to behavioral or mental health services or psychiatric treatment, treatment for substance abuse, or genetic test results.

I understand that once the information is disclosed, the information is subject to re-disclosure and may no longer be protected by the federal privacy regulations. This form may be revoked at any time providing the information has not already been disclosed. I have the right to revoke this authorization at any time. Revocation must be made by notifying, in writing, the Privacy Officer, 1790 E Venice Ave. Ste. 204, Venice, FL 34292.

I understand that this authorization will be in force and effect until the day I revoke this permission or (7) seven years from date signed below, whichever occurs first, unless otherwise specified on the following date/event/condition_____.

I understand that my authorizing the disclosure/obtaining of this health information is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization. I understand that I may inspect or copy information to be used or disclosed as provided by law. Fees may be applied and billed by Cornerstone Psychiatric to me (patient) or if applicable to attorney, disability case vendor, insurance vendor or other vendor requesting such records. Fees are a $1.00 per page for pages 1-25 and $.25 for pages greater than 25. No fees applied when sending to /receiving from another provider of care for the purpose of Continuity of Care.

I understand the matters discussed on this form. I release the provider, its employees, officers and directors, medical staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

X_____ _____
*Signature of Patient or Patient's Representative** *Date*
**If a personal representative of the patient signs the authorization, please indicate his or her authority to act.*

_____
Initials or signature of CPS Staff (not required)

A COPY OF THIS DOCUMENT SHALL SERVE AS AN ORIGINAL