CENTER FOR
VITALITY AND BALANCE

AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

PATIENT INFORMATION

_____ _____

Patient Name Patient Date of Birth

I hereby freely and voluntarily authorize Sandra G. Carey, PsyD, MS to disclose information to:

_____

_____

AUTHORIZATION FOR MEDICAL RECORDS DISCLOSURE

The purpose of this disclosure is _____

By initialing the spaces below, I specifically authorize the release or disclosure of the following information and/or records, if such information and/or records exist.

_____ Continuity of Care

_____ Psychiatric Consultation

_____ Family Support

_____ Other

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment. I understand that I may revoke this authorization at any time, provided that I do so in writing and submit it to Sandra G. Carey, PsyD, MS. The revocation shall be signed by me and be witnessed by a person who can attest to my identity. Any revocation will take effect when Sandra G. Carey, PsyD, MS receives the revocation, except to the extent that Sandra G. Carey, PsyD, MS has already relied on the authorization.

I understand I have the right to inspect or copy any information to be used or disclosed under this authorization. I understand that no person or agency to whom any information is disclosed may re-disclose the information unless I specifically consent to re-disclosure.

Unless otherwise revoked, this authorization will terminate on _____ or one year from the date it was signed, whichever is sooner.

SIGNED _____ DATE _____

PATIENT

WITNESS _____ DATE _____

CENTER FOR VITALITY AND BALANCE
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