

DISCLOSURE TO RELEASE/OBTAIN PATIENT INFORMATION



Noetic Psychiatry

Patient Information

Patient Name: _____

(Last)

(First)

(Middle Initial)

Patient Social Security Number: _____ Patient Birthdate: ____/____/____

Email Address: _____@_____ Phone Number:(____)____-_____

Address: _____

(Street and Apartment Number)

(City, State)

(Zip Code)

Mailing Address: _____

(P.O. Box, Street, or Apartment Number)

(City, State)

(Zip Code)

Recipient of Health Information

I hereby authorize Noetic Psychiatry, it's staff, and providers to:

Disclose to

Request from

Person/Organization: _____

Email Address: _____@_____ Phone Number:(____)____-_____

Address: _____

(Street and Apartment Number)

(City, State)

(Zip Code)

Information to be Disclosed

All of my medication, health information, and records, including medical and mental health history, lab results, diagnoses, treatment, and prescriptions (*excluding psychotherapy notes, for which a separate disclosure authorization must be obtained, and is at the discretion of Noetic Psychiatry and their providers*).

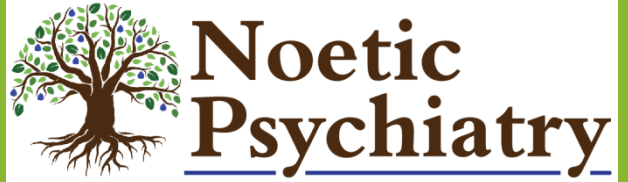
Only my billing, payment, appointment scheduling, and appointment history information.

Inpatient/Residential mental health treatment information.

Alcohol/Drug history, use, diagnosis, and treatment.

Only the following information: _____

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Expiration and Revocation

This authorization will expire on the date that is **six(6) months** from the date of my signature below.

I understand that Noetic Psychiatry cannot condition my treatment, payment, enrollment, or eligibility for benefits on my provision of this authorization.

I understand that information disclosed pursuant to this authorization, except for alcohol/drug treatment records that are protected by 42 CFR Part 2, may be subject to redisclosure by the recipient and no longer protected by HIPAA.

I understand that I have the right to receive a copy of this authorization.

Patient/Parent Signature: _____

Printed Name: _____ Date: _____

Relationship to Patient: Self Spouse Guardian Parent Temporary Caregiver