NeuroPsychiatry Center - Ravi Kant, MD, P.C.
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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, _____ date of birth _____, do hereby consent to and authorize to
Patient's Name (Print)
disclose health information about me and that can be identified with me from my records relating to my identity, diagnoses, prognosis, and/or treatment, which records may include information related to medical conditions, tests, mental or behavioral health, and substance abuse (drug and alcohol), and HIV-related. These records are called protected health information and are protected by federal and/or state law.

From _____ **Ravi Kant, MD, P.C.** _____
(Name and address of provider or facility releasing records)

To _____
(Name and address of provider, facility, or family member where records are being released to)

€ I authorize the entities named above to share the health related information related to my care.
Initial_____

The purpose or need for this disclosure is _____

I understand that the specific types of records to be released (identify all records or all that apply) are:

☐ All records including Psychiatric/psychological evaluation
☐ Laboratory reports & tests ☐ Physician notes only ☐ Acupuncture ☐ Other (specify) _____
☐ Insurance claims and payments only (including Medicare and Medicaid)

****Mental or behavioral health, substance abuse, and HIV-related information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated.****

DO NOT RELEASE: ☐ Mental/Behavioral Health (Psychiatric) ☐ HIV-Related ☐ Substance Abuse (Drug and Alcohol)

I understand that this authorization is revocable except to the extent that action has been taken in reliance thereon and that this consent will remain in force no more than **12 months** from the date of execution in order to effectuates the purposes for which it is given. I also understand that any revocation of this authorization must be in writing and sent or delivered to health care provider's office. I also understand that my decision to revoke this authorization may result in my insurance company not being able to pay for my medical care and I will be liable for payment for the services rendered.

Patient Signature _____ **Date** _____
(If patient is a minor (ages 14-18) he/she must sign this Authorization for Release of Protected Health Information Form)

Print Name _____

Responsible Party Signature _____ **Date** _____
(Parent/Guardian/Legal Representative)

Print Name _____

Relationship to Patient _____
(Guardian/Legal Representative may be required to attach supporting legal documentation)

Office Use Only
Witness _____ Name _____ Date _____