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

Patient Name:_____ **Date of Birth:**_____
Phone Number:_____ **Email:**_____

I consent to and authorize to disclose my protected health information relating to my identity, diagnoses, prognosis, and/or treatment. These records may include information related to medical conditions, tests, mental or behavioral health, 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: ☐ PCP ☐ Family Member ☐ Other Medical Provider ☐ Other_____

Name: _____
Address: _____
Phone Number: _____
Fax Number: _____

The purpose for this disclosure is: ☐ Coordination of Care ☐ Disability Application ☐ Other_____

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 ☐ Scheduling appointments/Medication refills
☐ Insurance claims and payments only ☐ Other_____

****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 upon my written request and that this consent will remain in force unless revocation from the patient or legal guardian is received. I also understand that any revocation of this authorization must be in writing and sent or delivered to my 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 _____