Michele O'Fallon, M.D. Laurie Montano, M.D.
Board Certified Internal Medicine & Pediatric Specialists

1) ____
Name Address City State Zip

______________ (____)______________ ______________
Date of Birth Daytime Phone Previous Name

2) **AUTHORIZES:**

____
Name of Health Care Provider / Plan / Other

____
Address

3) **TO DISCLOSE TO:**

☐ Self [I hereby authorize ______________________ to pick up my records. (Photo ID required).]

☐ ____
Name of Health Care Provider / Plan / Other

____
Address

4) ☐ **CHECK HERE IF AUTHORIZATION IS RECIPROCAL (in other words, the disclosing party and the recipient(s) may mutually exchange the information noted below.)**

5) **DATE(S) OF INFORMATION TO BE DISCLOSED:** From __________ (month/year) to __________ (month/year) If left blank, information from the past two (2) years will be disclosed.

6) **INFORMATION TO BE DISCLOSED:** ☐ Verbal ☐ Written

☐ Alcohol / Drug Abuse Assessment ☐ Discharge Instructions ☐ Discharge Summary ☐ History & Physical
☐ Identity and Presence in Treatment ☐ Initial Mental Health Assessment ☐ Lab Results ☐ Legal Status/Court Records
☐ Medications/Medication Profile ☐ Outpatient Mental Health/AODA Records ☐ Progress Notes/Updates
☐ Psychiatric Evaluation ☐ Psychosocial Assessment ☐ Treatment Plan
☐ Billing Records related to (specify): ______________________
☐ Other (specify): ______________________

____

☐ **CHECK HERE IF YOU DO NOT WANT HIV TEST RESULTS (IF THEY EXIST) TO BE DISCLOSED**

7) **EXPIRATION:** This Authorization is good until the following date / event: ______________________
Note: If this item is left blank, the authorization will expire in one (1) year from the date signed.

8) **PURPOSE** (check all that apply): ☐ Care Coordination ☐ Further Follow-up Care ☐ Insurance Eligibility / Benefits
☐ Legal Investigation/Action ☐ Obtain Collateral Information ☐ Personal (at my request) ☐ Verify Compliance with Treatment
☐ Other: ______________

9) **YOUR RIGHTS WITH RESPECT TO THIS AUTHORIZATION:** I am aware that I have the right to inspect and receive a copy of the health information I have authorized to be used and/or disclosed by this Authorization. I understand that I may be charged a fee for record copies. In addition, I understand that I do not need to sign this Authorization in order to receive treatment. I also am aware that I may revoke this Authorization by notifying the medical records/health information department in writing. However, I understand that my revocation will not be effective as to uses and/or disclosures: (1) already made in reliance upon this Authorization; or (2) needed for an insurer to contest a claim / policy as authorized by law if signing the Authorization was a condition to obtaining insurance coverage. I realize that the information used and / or disclosed pursuant to this Authorization may be subject to re-disclosure and no longer protected by federal privacy law.

10) **SIGNATURE OF PATIENT:** ______________________ **DATE:** __________

SIGNATURE OF LEGAL REPRESENTATIVE: ______________________ **DATE:** __________

If signed by a LEGAL REPRESENTATIVE, complete the following:

1. Individual is: ☐ a minor ☐ legally incompetent or incapacitated ☐ deceased
2. Legal authority: ☐ parent* ☐ legal guardian ☐ next of kin/executor of deceased ☐ activated POA for Health Care

* By signing above, I hereby declare that I have not been denied physical placement of this child.

For Office Use Only:

AUTHORIZATION FOR DISCLOSURE OF MENTAL HEALTH AND/OR ALCOHOL/DRUG ABUSE INFORMATION
(Consent)

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FAMILY AND FRIENDS APPROVED DISCLOSURE LIST

NAME OF PATIENT (PRINT)____

WE UNDERSTAND YOU MAY HAVE CONCERNED RELATIVES, FRIENDS, OR SIGNIFICANT OTHERS.

PLEASE LIST THE NAMES OF THOSE PEOPLE THAT WE MAY SHARE INFORMATION WITH.

WITHOUT YOUR WRITTEN CONSENT, THIS INFORMATION WILL NOT BE RELEASED.

____________________________________**PHONE**__________________

____________________________________**PHONE**__________________

____________________________________**PHONE**__________________

____________________________________**PHONE**__________________

PATIENT'S SIGNATURE____

DATE ______________