NAPA
NORTH ALABAMA
PSYCHIATRIC ASSOCIATES, P.C.

953 Jeff Rd. NW Huntsville, AL. 35806
(P) 256- 322-6272 * (F) 256-322-4987

Heath Penland, MD
Heidi Hollinger, CRNP, PMHNP
James Taylor, LPC

Authorization for Release/Request of Protected Health Information

Name: _____ DOB: _____ Last 4 of SS#-_____

I hereby authorize the release of the following specific information (circle all items that apply):

YES **NO** 1. Medical History
YES **NO** 2. Psychological test/psychiatric evaluation/neurological workup
YES **NO** 3. Social History, including family, education, employment, arrest and drug use information.
YES **NO** 4. Summary of previous mental health treatment
YES **NO** 5. Periodic reports of current treatment, including attendance, participation and urine drug screen results.

YES **NO** 6. Other (Specify) _____

Date(s) of Treatment to be released: _____

To/From: _____

Address: 953 Jeff Rd. NW, Huntsville AL. 35806

Phone: 256-322-6272 **Fax:** 256-322-4987

From/To: _____

Address: _____

Phone: _____ **Fax:** _____

I understand that this information will be used for the following specific purposes (Circle Yes or No)

YES **NO** 1. To develop a diagnosis, treatment, and rehabilitation plan
YES **NO** 2. To coordinate medical, psychological and social rehabilitative process
YES **NO** 3. To process insurance claims for services provided (diagnosis, number of visits, modalities, and expected length of treatment)
YES **NO** 4. Other (specify) __**TO COORDINATE PATIENTS CARE or TRANSFER PATIENTS CARE**_

I voluntarily allow the release of the above information. No threat or other measures have induced me to sign this consent form. I may revoke this at any time.

_____ Date: _____
Patient Signature

_____ _____
Parent/Patient Representative Signature (If Applicable) Printed Name and Relationship to Patient (If Applicable)

_____ Date: _____
Witness Signature

Unless otherwise noted, this authorization will expire on the following date _3 Years or upon Termination of Services. This authorization is valid for one year from the date listed above. You may revoke this authorization at any time by notifying **NAPA** in writing, but such revocation will have no effect on disclosures of information already made under this authorization prior to receipt of the revocation. This authorization is voluntary, and you may refuse to sign the authorization and the patients' treatment, or payment obligations will not be affected by this authorization unless (i) the treatment is related to research and the use and/or disclosure is related to such research, or (ii) the treatment is solely for the purpose of creating protected health information for disclosure to a third-party. Upon signature, you may receive a copy of this authorization. The information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by state or federal law. **NAPA** will not receive financial or in-kind compensation or remuneration in exchange for the use and/or disclosure of the patient's information unless an applicable legal exception applies. This authorization is continuing in nature and is to be given full force and effect to release any and all of the foregoing information learned or determined after the date hereof until the expiration date. I hold **NAPA** its employees, associates, directors, officers, agents and representatives harmless from any and all damages which might result to myself, the patient, our representatives, heirs, and/or assigns from the disclosure of this information. A copy or facsimile of this authorization shall be valid and effective, just as the original.