HUDSON PSYCHIATRIC
ASSOCIATES, LLC
www.hudsonpsych.com

Authorization to Release Health Information Pursuant to HIPAA

patient name	birth date

name of health provider or entity to release this information

address of health provider or entity to release this information

purpose of release	event or date authorization will expire

I, or my authorized representative, request and authorize that health care information regarding my care and treatment be released as described below:

___ Complete Medical Record
___ Other:

I *specifically authorize* the release of the following types of highly confidential information: AIDS or HIV, Mental Health Information, and Sexually Transmitted Diseases.

I understand that, unless action already has been taken in reliance on this authorization, I may revoke this authorization at any time by making a written request to Hudson Psychiatric Associates, LLC.

I understand that signing this authorization is voluntary and that Hudson Psychiatric Associates, LLC, may not condition treatment, payment, enrollment or eligibility for benefits on my signing this authorization, unless my treatment is related to research and the purpose of this authorization is to enable the protected health information described above to be used for such research.

I understand that information disclosed based on this authorization may be subject to redisclosure by the recipient, and no longer protected by federal or state privacy regulations.

I have received a copy of this authorization.

signature of patient or authorized representative	date
name of authorized representative (if applicable)	authority of representative

signature of witness