Perfect Balance Psychiatric Services and TMS Center

AUTHORIZATION TO RELEASE /OBTAIN PROTECTED HEALTH INFORMATION (PHI)

PATIENT NAME: ____________________________________ **DOB:** _______________

I hereby authorize PERFECT BALANCE PSYCHIATRIC SERVICES PLLC to use disclose, obtain, or release my protected health information (medical records) to/from the named individual or organization listed below. Please fully complete the form. Incomplete forms will be null and void.

☐ **COPY OF COMPLETE MEDICAL RECORDS**

☐ **COMPLETE BILLING RECORDS**

☐ **ALL PHARMACY/ PRESCRIPTION RECORDS**

☐ **ALL DISABILITY, PERSONAL AND WAGE RECORDS**

THIS PROTECTED HEALTH INFORMATION IS DISCLOSED FOR THE FOLLOWING PURPOSES: _________________________________

I consent my PHI disclosed to the following individuals:

1) ________________________ __________________ ______________________________

FULL NAME **RELATIONSHIP** **TELEPHONE NUMBER/FAX NUMBER**

2) ________________________ __________________ ______________________________

FULL NAME **RELATIONSHIP** **TELEPHONE NUMBER/FAX NUMBER**

3) ________________________ __________________ ______________________________

FULL NAME **RELATIONSHIP** **TELEPHONE NUMBER/FAX NUMBER**

- **I understand that specific information to be disclosed may include Drug, Alcohol Abuse or Mental Health Treatment, information regarding communicable diseases including Human Immunodeficiency Virus (HIV), acquired immunodeficiency syndrome (AIDS), and other medical conditions, laboratory results, treatment and any such related information.**
- **I understand that the information released pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA privacy regulations.**
- **I authorize that a photocopy of this authorization is acceptable as an original.**
- **This authorization will remain in effect indefinitely unless revoked in writing. I understand that my treatment is not conditioned upon my providing this authorization. I understand that I have the right to revoke the authorization at any time by providing a written notification to: The Privacy Officer, Perfect Balance Psychiatric Services, and 9300 John Hickman Parkway, Suite 101, Frisco, Texas 75035. Perfect Balance Psychiatric Services shall not be deemed responsible for release of any information pursuant to this authorization prior to revocation.**
- **I understand that there will be a charge of release of photocopies of my medical record. Please indicate below if you need the photocopies of your medical record to be sent to the above named individual or organization.**

SIGNATURE OF THE PATIENT: _________________________________ **DATE:** ______________

(Guardian's signature if patient is under 18)