Russell Denea, MD, LLC

Psychiatry and Psychoanalysis
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Saint Augustine, FL 32080
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www.drdenea.com

Name: _____ Date of Birth: _____ Sex: ❑F ❑M

I authorize **Russell Denea, MD, LLC.** to: ❑ obtain ❑ provide to

Provider/Agency (*include the group name*): _____

Address: _____

_____

Telephone: _____ Fax: _____

Specific Information:

- ❑ Psychiatric Evaluation
- ❑ Admission Assessment
- ❑ Consultation Reports
- ❑ Psychological Testing
- ❑ Medication Record
- ❑ Discharge Summary
- ❑ HIV/AIDS/STD History & Treatment
- ❑ Drug & Alcohol History & Treatment
- ❑ H & P, Labs, AIMS, X-Rays, EEG, Scans
- ❑ Progress Notes
- ❑ Clinical Summary
- ❑ Financial/Billing Information
- ❑ Other _____

This information will be used for:

- ❑ Evaluation
- ❑ Continuing Treatment
- ❑ Other _____
- ❑ Coordinating Care
- ❑ Insurance Application
- ❑ Insurance Claims

I understand that:

1) I understand that signing this consent is voluntary. My treatment, payment, or enrollment in a health plan will not be affected.

2) If I am authorizing the release of mental health treatment or alcohol or drug abuse records, the recipient is prohibited from re-disclosing such information without my authorization unless permitted to do so under federal or state law.

3) The above information may be protected by Federal Regulation 42 CFR, part 2 "Confidentiality of Alcohol & Drug Abuse Patient Records", and cannot be disclosed without my written consent, unless otherwise provided for in the regulations.

4) Information disclosed under this authorization might be re-disclosed by the recipient (except as noted in item 2), and this re-disclosure may no longer be protected by federal or state law.

Authorization

1. I hereby authorize the release of the above requested information to/by Russell Denea, MD, LLC

2. I understand that this consent will be valid until revoked by me in writing and that a copy may be used in place of the original.

Signature: _____
Date: _____
Witness: _____
Date: _____

Revocation of Authorization

1. I hereby revoke the authorization on this form. I understand this does not affect actions already taken by Russell Denea, MD, LLC prior to the date of revocation.

2. I understand that I may not be able to revoke this authorization if its purpose was to obtain insurance.

Signature: _____
Date: _____
Witness: _____
Date: _____