Baywell
Psychiatry Group

Administrative Office
582 Market Street, Suite 812
San Francisco, CA 94104
Tel 415-922-9122
Fax 415-920-9925
www.baywellpsych.com

Authorization for Use or Disclosure of Protected Health Information

Completing this document authorizes Baywell Psychiatry Group ("Baywell") to use, disclose, or request health information about you. Failure to provide all information requested may invalidate this Authorization.

Patient Name: _____ Date of Birth: _____

Use, Disclosure, or Request of Protected Health Information
I hereby authorize Baywell Psychiatry Group, administrative office located at 582 Market Street, Suite 812, San Francisco, CA 94104, to release or request health information described below to the following person or organization:

_____
Specify Name/Title of person or institution

_____
Specify Address, Telephone Number and Fax Number

Information to be Used or Disclosed: (check all that apply and initial applicable lines below)
___ Mental health or developmental disability treatment records (excludes "psychotherapy notes")
___ Substance abuse treatment records
___ HIV/AIDS test results (This authorizes disclosure of laboratory test results only.
(**Note that your records may include information concerning substance abuse treatment and/or HIV status even if you do not initial these lines**.)

The Following Records: specific types of health information or records for the date(s) of treatment as specified (check applicable lines below)
___ **All Records** regarding my treatment and outpatient care.
A separate authorization is required for the use or disclosure of psychotherapy notes.
If you need to specify further:
___ Assessment/Evaluation ___ Diagnosis
___ Laboratory Results ___ Progress Notes
___ Billing Reports ___ Treatment Summary
___ Medication History ___ Other (Specify):_____
___ Date(s):_____

Purpose
The purpose of the requested use or disclosure is (check all that apply):
___ My request ___ Health Care Provider Request
___ Legal ___ Other (Specify): _____

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Expiration of Authorization

This authorization is valid until _____. (Specify date or terminating event.) If no date or event is indicated, this authorization will expire 12 months after the date of my signing this form.

My Rights with Respect to This Authorization

I understand that I have the following rights:

- I may refuse to sign this Authorization. My refusal will not affect my ability to obtain treatment, or payment, or eligibility for benefits unless: (i) my treatment is related to research, in which case I will not be permitted to have treatment without signing this Authorization; or (ii) if/when I am receiving health care solely for the purpose of creating information for disclosure to a third party, in which case I may not receive care unless I sign the Authorization.
- I may inspect or obtain a copy of the health information that I allow the use or disclosure of.
- I have a right to receive a copy of this Authorization.
- I may revoke this Authorization at any time. The revocation must be in writing, signed by me or my personal representative, and delivered, mailed or faxed to:

Baywell Psychiatry Group
Attn: HIPAA Privacy Officer
582 Market Street, Suite 812
San Francisco, CA 94104
Fax: (415) 920-9925

I understand that information disclosed as a result of this Authorization could be redisclosed by the recipient. I understand that if I authorize the disclosure of health information to an individual who is not legally required to keep it confidential, it may no longer be protected by state or federal laws.

- I have read and understand the terms of this Authorization. I have had an opportunity to ask questions about the use and disclosure of my medical information.

Signature: _____ Date: _____

If signed by someone other than individual to whom the health information pertains, state the name, relationship, and authority to sign authorization on individual's behalf, and attach any supporting documentation to this request:

Name: _____ Relationship: _____

Witness (if patient unable to sign): _____