RENÉE BIBEAULT, M.D.

PSYCHIATRY FOR WOMEN

CONSENT FOR RELEASE OF PROTECTED HEALTH INFORMATION

This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Print Name of Patient _____

Date of Birth _____ SSN _____

I. MY AUTHORIZATION

I authorize Dr. Renee Bibeault, the disclosing party:

to use or disclose the following health information.

☐ All of my health information, including information about mental or emotional symptoms, physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment.

☐ My health information covering the period from _____ (date) to _____ (date)

☐ Other _____

The above party may disclose this health information to the following recipient:

Name (or title) and organization _____

Address _____

City _____ State _____ Zip _____ Phone _____

Email _____ Fax _____

This authorization ends:

☐ On (date) _____

☐ When the following event occurs: _____

II. MY RIGHTS

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party. I understand that uses and disclosures already made based upon my original permission cannot be taken back. I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards. I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

Signature _____ Date _____

SUBMIT