Kathryn Eckstein Jalovec, M.D.
Child, Adolescent and Adult **Psychiatry**

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Authorization to Release Information

Patient's Name: _____ Date of Birh: _____

I hereby authorize Kathryn Jalovec, MD and its physicians, employees and agents to release and/or communicate to the below named person or organization all of my medical records including any specially protected records such as those relating to psychological or psychiatric impairments, drug abuse, alcoholism, sickle cell anemia, or HIV infection. Also, I authorize the following person/organization to send a copy of my protected health information (PHI) and /or communicate about my health care to Kathryn Jalovec, MD, and her staff.

Name: _____

Address: _____ City, State, Zip: _____

Phone: _____ Fax: _____

Purpose of Disclosure:
This authorization will expire on the following date or upon the occurrence of the following event:
(If left blank, authorization will expire 12 months after the date of signature below.)

Please initial one number below

1. All records at this facility ..... Initials _____
2. Only records generated by the above-named health care provider (not including records received from other sources) ..... Initials _____
3. Only a portion of records maintained by the above-named health care provider (dates of treatments, etc.) please specify: _____ Initials _____

If you DO NOT WANT certain portions of your medical recorded released, please read this section carefully and initial the boxes for information you do not want released. Otherwise your records will be released as specified above.

*I authorize the above-named health care provider and its physicians, employees, and agents to release the information specified to the organization, agency, or individual named on this request with the exception of:

Substance abuse *(if any)* _____ Initials Psychological or psychiatric conditions *(if any)* _____ Initials AIDS/HIV/STDs *(if any)* _____ Initials

*I understand that I may revoke the Authorization at any time prior to the expiration date or event, but that my revocation will not have any effect on actions taken by the above-named health care provider or its physicians, employees or agents before they received my revocation. Should I desire to revoke this Authorization, I must send written notice to the above-named healthcare provider.

*I understand that I am not required to sign this Authorization. The above-named health care provider will not condition treatment, payment, enrollment or eligibility for benefits on whether I provide this Authorization.

*I understand that my records may be subject to disclosure by the recipient and may no longer be protected by federal privacy regulations. I understand that this Authorization does not limit the above-named healthcare provider's or its physicians', employees', or agents' ability to use or disclose my information for the treatment, payment or health care operations or as otherwise permitted by law.

Patient or Authorized Representative's Signature _____

Date: _____ Relationship to the patient: _____