AUTHORIZATION FORM

1. Patient Name: _____ Date of Birth: _____

The undersigned hereby authorizes the sharing of the following Protected Health Information regarding the individual (patient) named above.

□ From:_____ ⇒ To: Dr. Pois & his administrative staff
□ To: _____ ⇐ From: Dr. Pois & his administrative staff
(**Marking both boxes** permits the **two-way exchange** of information between parties).

_____
(Organization)
_____
(Street Address)
_____

_____
(City, State & Zipcode)
_____
(Telephone number &/or Facsimile number)

Seth W. Pois, M.D., P.S.C.
Child, Adolescent & Family Psychiatry
1300 Clear Springs Trace
Suite 7
Louisville, Kentucky 40223
Telephone (502) 425-5422
Facsimile (502) 425-5424

I understand that the following items from my Protected Health Information will be shared: (as marked below):

□ Evaluation Report □ Psychosocial History □ Laboratory Results
□ Psychological Testing □ Admission Summary □ Consultation Reports
□ Medication Assessment □ Discharge Summary □ Treatment Plan & Summary
□ Recommendations □ History & Physical □ Verbal Communication
□ Educational Records □ Other: _____

I understand the purpose for sharing this information is for:
□ Continuity of Care □ Evaluation □ Insurance Claim □ Other: _____

2. I understand that I may refuse to sign this authorization and that Seth W. Pois, M.D., P.S.C.. will not allow my refusal to interfere with the receipt or payment of behavioral health services.

3. I understand that this authorization for release or obtaining information is subject to revocation at any time in writing to Seth W. Pois, M.D., P.S.C.. (at the address listed above) except to the extent that action has been taken based on my authorization; or obtained my authorization for the purpose of receiving reimbursement from a third party payer.
Unless previously revoked, this authorization shall expire***** on: _____; or after the following event has occurred or condition has been met: _____
_____.

*****(expiration date of **90 days from date** of consent for one time release and one year for releases to persons providing *on-going services* to the patient such as school personnel, psychiatrists, pediatricians, etc.)

4. I understand that pursuant to KRS 304.17A-555—Patient's Right to Privacy Regarding Mental Health or Chemical Dependency—Authorized Disclosure, my Protected Health Information, used and/or shared under this authorization may not be shared again by the recipient of the information beyond the purpose for which my authorization was given, without first obtaining my specific written consent to redisclosure.

I have read and understand this authorization. I have been provided with a copy of this authorization**.

_____ _____
Signature of Patient *or Legal Guardian if patient is under 18 years of age* **Date**

_____
(Relationship to Patient)

_____ _____
Signature of Witness **Date**

_____
(Title)
**Original authorization placed in patient's file. Copy of authorization sent with information released.
SWP Rev 3/24/2003