**AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION**

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Previous Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I request and authorize \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ at address/phone#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to release healthcare information of the patient named above for the purpose of evaluation/determination of Transcranial Magnetic Stimulation (TMS Therapy) TO (via email/fax/mail/email):

**TMS Center of the Lehigh Valley/ Paul K. Gross, M.D.**

**401 N. 17th Street**

**Allentown, PA 18104**

**Phone: 610-820-0700, Fax: 610-820-8647**

**Email:** **cgillen@tmslv.com**

I authorize the following information to be released from my mental/behavioral health records: Date(s) of Service: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mental Health and/or Drug and Alcohol Treatment Records that are authorized to be released: Please check the appropriate item(s):

 o History and Physical o Group Therapy Notes

 o Medication list including Start and Stop dates & dosage o Psychological Testing Results

o Psychosocial Assessment o Psychotherapy Notes

o Psychiatric Eval/Tests o Drug/Alcohol abuse treatment

o Psychosocial Eval/Tests o Communicable diseases incl. HIV/AIDS

I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon this authorization the facility, its employees, officers, and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. The information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient and no longer protected by federal law, except for drug and alcohol treatment information.

**I understand that I am entitled to a copy of this authorization.**

**Printed Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient/Legal Representative Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Time**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Relationship to Patient**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NOTICE If the attached records contain information regarding mental health and/or drug and alcohol treatment please read and follow the information presented below.

This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains to or as otherwise written permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

**This authorization expires one year after it is signed.**