Northern Virginia Psychiatric Group, P.C.

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Rockville, MD 20850

Patient Authorization to Use or Disclose Health Information

I, _____, understand NOVAPSY is authorized by me to use or disclosure my protected health information. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information. I specifically authorize any current employee or owner of NOVAPSY, or any other individual listed below to disclose my protected health information as described on this form to the recipient(s) listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization, if done so according to the steps set forth below.

Description of the disclosure being requested *(check all that apply)*:

[ ] SEND COPIES OF ALL PROGRESS NOTES FOR THESE PROVIDERS: _____

[ ] SEND COPIES OF PROGRESS NOTES FOR SPECIFIC DATES OF SERVICE: _____

[ ] SEND COPIES OF LAB RESULTS ORDERED BY NOVAPSY PHYSICIAN

[ ] SEND LETTER CONCERNING MEDICAL CARE

[ ] COMPLETE STANDARDIZED FORMS

[ ] VERBAL COMMUNICATION

Name(s) or class of person(s) authorized by this form who may use and disclose the patient's protected health information: This authorization permits NOVAPSY to send the protected health information ONLY to this **address or fax number**:

Release/send to [ ]
OR
Obtain from [ ]

Name: _____
Address: _____
_____
Fax #: _____

Purpose(s) of the information: [ ]Transfer of Care [ ]Coordinate Care [ ]Other: _____

The patient has a right to revoke this authorization, except to the extent that action has been taken in reliance on this authorization or, if applicable, during a contestability period. ALL revocations must be sent in writing to NOVAPSY to the attention of the Privacy Officer, Dr. Robert Castino, via Certified U.S. Mail or faxed to 703-573-2351, and are not effective until received. The revocation must include:

- the patient's name, address, and patient number, if applicable,
- the patient's desire to revoke this authorization, and
- the date of the revocation, and the patient's signature.

This authorization shall expire on _____. After this date, NOVAPSY can no longer use or disclose the patient's protected health information without first obtaining a new authorization form. If left blank, release will expire 2 years from date signed.

I fully understand and accept the terms of this authorization.

_____ _____ _____
Patient/ Guardian Signature Patient Date of Birth **(required)** Date

$10 PROCESSING FEE + COPYING CHARGES (.50/page for first 50 pages, then .25/page) FOR ALL COPIES SENT. YOUR PROVIDER MAY CHARGE FOR COMPLETION OF FORMS.

PAYMENT INFO (cc# w/exp. date): _____

DAYTIME PHONE #: _____