ARNOLD F. NEGRIN, M.D.
CHILD, ADOLESCENT & FAMILY PSYCHIATRY
821 STEPHENSON AVENUE
SAVANNAH, GEORGIA 31405

AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION

Patient Name: _____ **Date of Birth:** _____

Address: _____

I hereby authorize the office of Arnold F. Negrin, Psychiatry, to disclose, release, or exchange protected health information, with these parties below:

Name of Person or Office: _____

Address: _____

Phone Number: _____ Fax: _____

Information to be Released

☒ Medical History, Examination Reports
☒ Treatment or Tests
☒ Prescriptions
☒ Therapy Notes and Consultations
☒ Diagnostic Studies
☒ Laboratory Reports
☒ Substance Abuse
☒ Consultations
☒ Mental Health
☒ Developmental Disabilities
☒ Psychological Evaluations
☒ Hospital Records & Reports

Purpose of the Requested Use or Disclosure is:

☐ At the request of the individual
☒ Continuity of Care
☐ Other: _____

I understand that the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information might be re-disclosed without obtaining my authorization. I understand that I have a right to:

- Receive a copy of this authorization
- Refuse to sign this authorization and that treatment, payment, enrollment in health plan, or eligibility for healthcare benefits may not be contingent on my signing this authorization.
- Revoke this authorization, except to the extent that the person(s) and/or organization(s) listed above have already made in reference to this authorization.

This authorization will remain in effect while under the care of this provider, unless an earlier date or event is specified, or with the written revocation of this authorization:

☒ While under care of provider(s)
☐ Specific date of revocation of this authorization: _____

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Printed Name of Patient or Legal Representative Relationship or authority to act on patient's behalf