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HIPAA RELEASE OF INFORMATION FORM (for Dr. Jeffrey Desarbo)

Patient Name: _____ Date of Birth:_____

Address: _____

Phone Number: _____ Email: _____

I, the undersigned, hereby authorize the release of my protected health information as described below. I also grant Dr. Jeffrey DeSarbo permission to speak via telephone or email to clinical providers listed below.

Types of Information to be Released (check all that apply): [ ] Medical Records [ ] Psychiatric Records [ ] Treatment Summaries [ ] Medication History [ ] Laboratory Results [ ] Diagnostic Imaging Results [ ] Neuropsych Testing [ ]

Other (specify): _____

Provider(s) Information:

*Medical Provider:*_____

Address:_____Phone:_____

*Medical Provider (specialist):*_____

Address:_____Phone:_____

*Psychiatrist:*_____

Address:_____Phone:_____

Psychotherapist: _____

Address:_____Phone:_____

*Nutritionist:*_____

Address:_____Phone:_____

Other (name/specialty): _____

Address:_____Phone:_____

I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal privacy regulations. This authorization shall remain in effect until revoked by me in writing. I understand that I have the right to revoke this authorization at any time, except to the extent that action has already been taken in reliance on this authorization. Revocation must be in writing and sent to the provider. I understand that I am not required to sign this authorization and that my treatment, payment, enrollment, or eligibility for benefits will not be affected if I refuse to sign.

Patient Signature: _____ Date: _____

If a Minor:

Parent/Guardian Name: _____Relationship: _____

Parent/Guardian Signature:_____Date: _____

Please retain a copy of this form for your records. If you have any questions about this form, please feel free to ask.