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AUTHORIZATION FOR RELEASE OR SHARING OF MEDICAL INFORMATION

This authorization is for the use or disclosure of health information pertaining to:

Patient's Name: _____

Social Security# _____ *Date of Birth:* _____

I hereby authorize:

_____ **Dr. Timothy Murphy** to release my medical and mental health information **to**
the Person or Organization below:

Name of Person or Organization Receiving and/or Releasing Information:

Name

Street Address *City, State and Zip*

Phone *Fax* *email*

Information to be released will include mental health, general health and drug/alcohol use information. Disclosure is specifically requested for:

Treatment Summary All Medical Records Labs Psychological Testing
 Psychological Testing Exchange of Info by Phone Other (specify): _____

Purpose: Records are being released for the following purpose:

Ongoing Care Insurance Application Personal Use
 Disability or Workers Compensation Claim Other (specify) _____

My Rights: I understand that this authorization is voluntary, and that I may refuse to sign without affecting my eligibility for treatment. I may revoke this authorization at any time, provided that I do so in writing, except for information already disclosed. I understand that I may receive a copy of this authorization, and that I may review information that is to be disclosed. The recipient may not lawfully further disclose my health information unless another authorization is obtained from me, or unless the use or disclosure is specifically permitted by law.

Expiration of Authorization: Unless otherwise revoked, this Authorization will expire on _____ (insert applicable date). If no date is indicated, this Authorization will expire 12 months after the date of signing below.

Signature of Patient: _____
(required for ages 12 through adult) Date

Signature of Parent / Legal Guardian: _____
(required for all patients under the age of 18) Date

A photocopy or facsimile of this authorization may be accepted in lieu of the original.