INTEGRATIVE PSYCHIATRY OF NY, PC

Caroline Stamu-O'Brien, MD

99 Madison Avenue 5 Fl. Suite 531 New York, NY 10016

T (646) 430-5684 **F** (646)430-5631

CONSENT TO RELEASE PROTECTED HEALTHCARE INFORMATION

Integrative Psychiatry of NY, PC

Your Name (print clearly):_____DOB:_____

Guardian/Authorized Party:_____DOB:_____

Social Security Number:_____

I authorize Dr. Caroline Stamu-O'Brien, MD, Integrative Psychiatry of NY, PC, and any of the administrators and clinical staff of the practitioner who may be directly or indirectly involved in my care to disclose confidential and protected health information about me to the persons/agencies listed below. This confidential information includes, but is not limited to: my alcohol and drug use history, psychological/psychiatric history, medical history; family history, legal and financial status, treatment history, results of diagnostic tests, genetic tests, urine tests, and clinical progress reports; current or planned treatment I may receive; all aspects of my treatment and clinical progress; and, all other information deemed important by Dr. Stamu-O'Brien to assist with my treatment and/or other personal or business matters including but not limited to insurance reimbursement, legal action, regulatory action, personal, marital conflict, child custody, disability, research, continuity and coordination of care etc.

○ Yes ○ No I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS, or infection with any causative agent of AIDS, with the rest of my record.

○ Yes ○ No Psychotherapy Notes

I authorize release of this information to the following persons, family members, medical doctor, psychiatrist, psychologist, therapist, attorney, organizations, and/ or agencies:

Name_____Facility_____

Address_____

Phone Number:_____Fax Number:_____

Expiration Date of this Authorization:_____

I acknowledge that this consent can be revoked by me in writing and that I can do so at any time for any reason except to the extent that: (a) this information is deemed necessary to protect my personal safety and/or the safety of others who may be seriously affected by my behavior; (b) disclosure has already occurred; and, (c) any pending action already taken and/or in progress that relies on this disclosure. I understand that information disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by HIPAA or any federal or state law. I hereby release Integrative Psychiatry of NY, PC and its physicians/associates from any and all liability related to the release of information pursuant to this authorization.

Patient's Signature:_____Date signed:_____

If Minor, Guardian/Authorized Signature_____Date signed:_____