PSYCHIATRIC ASSOCIATES PC
5918 HARBOUR PARK DRIVE
MIDLOTHIAN, VA 23112

PLEASE PRINT

Patient Information

Patient: _____ DOB: _____ SSN:_____

Address:_____ City: _____ State_____

Zip Code: _____Sex: M ☐ F ☐ Marital Status: Married Single Divorced Separated Widowed

Home Phone: ( ) _____ Work Phone: ( ) _____ Cell Phone: ( ) _____

E-mail address: _____

CITY/COUNTY LOCATION _____

Custodial Parent/Guardian: _____SSN: _____

Address: _____ City: _____ State:____ Zip:_____

Home Phone: ( ) _____ Work Phone: ( )_____ Cell Phone: ( )_____

EMPLOYMENT:

Employer: _____ Address: _____

City: _____ State: ____ Zip: _____

INSURANCE INFORMATION

Primary Insurance: _____

Policy Holder: _____

Identification Number: _____

Group Number: _____ Phone Number: _____

Referral Needed? Yes No

Secondary Insurance: _____

Policy Holder: _____

Identification Number: _____

Group Number: _____ Phone Number: _____

Psychiatric Associates P.C.

OFFICE POLICIES AND FINANCIAL AGREEMENT

Thank you for choosing HMG PSYCHIATRIC ASSOCIATES as your healthcare provider. The following is a statement of our financial policy which we require you to read and sign prior to being serviced by the providers in the practice.

The practice does NOT accept walk-ins. If you are not on the schedule you may NOT see the provider. You must bring your appointment card to your appointments, to avoid conflict with those on the schedule, as at times it is possible, at the discretion of the provider, or to accommodate you on the schedule.

Payment is due in full at the time of services are rendered. If you have an outstanding balance on your account it needs to be paid in full or set up a payment plan before your next appointment. Failure to do so will result in your account being sent to collections.

It is your responsibility to verify your insurance coverage plan and obtain all necessary referrals before your appointment. Failure to do so may result in you being responsible for all charges. Please bring your insurance information for all appointment in order to update your account and keep it current.

Any patient requesting paperwork to be filled out or a statement, etc, will require a charge depending on the length of documentation requested and the discretion of the provider.

All prescriptions with or without refills are the patients responsibility once received. For controlled substances, we cannot authorize or give an early prescription prior to the end date due for refill. If your prescription is stolen or involved in relation to a crime you MUST, as a responsible citizen, file a police report. This is for your protection and that of the public. For liability reasons the prescribers WILL NOT & CANNOT give you an early refill.

This practice participates with the Virginia Prescription Monitoring Program. We may be monitoring your controlled prescription refill status as well all the other controlled medications you are receiving by any provider in the state of Virginia.

Why We Drug Test

Many patients don’t realize that the physician’s ability to continue to service the community can be severely limited or stopped entirely if patients misuse or divert their prescriptions.

We want to continue to serve you.

We want you to be safe.

We make it a policy to drug test.

You may be responsible for the cost of any drug test deemed medically necessary by the Health care Provider.

We thank for your cooperation.

HMG Psychiatric Associates, P.c. Reserves the right to dismiss any patient from the practice if found in violation of any of these policies. In the event you are dismissed from the practice you may receive a 30 day supply of your medications. During this 30 day period, in the event of an emergency the prescribing provider or on-call physician will direct you to be examined and to document said emergency at a suitable facility, Urgent Care Center, Emergency Department, etc.

WE ACCEPT CASH, OR CREDIT CARDS (MasterCard, Visa, or Discovery Card)

Regarding Insurance:

You will be asked to provide your insurance card(s) at EVERY visit. This is to ensure that the information we have is correct and that we participate with you plan. All office co-pays are to be paid at the time of service. This is an insurance company policy. If you do not have your co-payment, you may be asked to reschedule your appointment. We will submit insurance claims as a courtesy for our patients. However, the agreement of the insurance carrier to pay for medical care or therapy services is a contract between you and the carrier.

Insurances may vary in coverage, and it is the patient's responsibility to understand his/her medical benefits. There may be limitations and exclusions to coverage. The patient portion is set by the insurance company. Patients are responsive for any co-insurance, deductibles, or any non - covered service, which are due at the time of service. It is the responsibility of the patient to ensure we have a referral on file for your visit, if you have an insurance plan that requires one. If a referral was not obtained, you will be asked to sign a waiver or reschedule your appointment.

Medicaid and Medicare Recipients:

AS a Medicaid and Medicare recipient I understand that in addition to the above financial policy agreement, I accept full responsibility for all non-covered charges incurred while a patient, to include but not limited to: Phone consults, Reports, Prescription refills, Court Fees and Related Cost, etc (at the providers discretion)_____ (Initials)

Authorization for release of Information:

I authorize the release of information to be used for account billing purposes. _____ (Initials)

Assignment of Benefits:

In consideration of medical or therapy services rendered by this practice and/or contracted providers, to the extent permitted by law, I herby irrevocably assign, transfer and sign over to the practice all of my rights, title and interest to medical reimbursement payable to me for those services rendered during the pendency of the claim. Such irrevocable assignment and transfer shall be for the recovery of said policy (s) of insurance, but shall not be construed to be an obligation of the practice to pursue any right of recovery. I hereby authorize the insurance company or third party payer (s) to pay directly to the practice all benefits due for services rendered._____ (Initials)

Missed Appointments:

There is a $50.00 fee for missed appointments or appointments that are cancelled without giving us a 24 hour notice.

Collection Fees:

In the event we are placed in the unfortunate position that we must turn your delinquent account over to a Collection Agency and/or Collection Attorney, you will be responsible for all collection cost, including a recovery fee of 30 of the balance due, as well as court costs and attorney's fees that may be incurred.

Fees for forms and refill requests (due to cancelling or rescheduling a regular appointment)

Your physician and staff will be happy to fill out any necessary forms that you may need. Routine "Work Notes/Medical Excuses" will be processed without a fee. However, please be advised that due to the

time and process required to fulfill your request, we reserve the right to charge a fee for this service. These cost are considered non-covered by insurance companies, thus, payment of this fee is due at the time of the request. Your credit card may used to retain and charge for the fees in cured.

Charge for prescription refills: Prescriptions are generally written at the time of your appointment with enough refills to cover the time that your psychiatrist is comfortable allowing before seeing you again, so additional refills between visits should not be necessary. If a refill is required between visits, you will be charged a $20.00 fee for the time taken to review the chart and prepare/call-in the prescription. This fee is not covered by insurance and is your responsibility. Patient must call in for refill requests; we do not provide refills in response to pharmacy calls/faxes.

Telephone calls: Please save routine clinical updates and questions for your scheduled appointment. While there is not charge for brief calls, non-emergency calls lasting more than 5 minute or frequent non-emergency calls will be billed at a rate of $120.00 per hour, with a minimum charge of $30.00.

Court Testimony: The fee for any requested deposition or court testimony, regardless of whether the clinician is served a subpoena or requested to testify by one of the parties is $300.00 per hour with a minimum charge of $900.00 (for up to 3 hours). This includes time needed for preparation and travel. Additional fees may be assessed if travel outside of the immediate area is required.

Payment for court testimony: Payment in full for depositions and court testimony is required 5 business days in advance of the scheduled hearing. In the event that a deposition or hearing is cancelled less than 3 business days in advance, a charge of $300.00 will be assessed. Depositions or hearing cancelled with less than 24 hour notice will be assessed the full fee. Responsibility for the payment in full for any requested court testimony is ultimately yours, regardless of which party may have issued a subpoena. Fees for depositions and court testimony are not covered by insurance.

X_____ X_____

Signature of Patient or Responsible Party Date

X _____

Name of Patient or Responsible Party

PSYCHIATRIC ASSOCIATES

FINANCIAL AGREEMENT

PLEASE READ CAREFULLY

Summary of Fees

Effective JULY 1, 2016

Types of Service	**Associated Fees**
Initial Evaluation (Therapist/Counselors)	$200
Initial Evaluation (Psychiatrist)	$225
Psychiatric Follow-Up	$90-$200
Prescription refills between appointments	$20
Individual Therapy (60 min.)	$150
Individual Therapy (45 min.)	$125
Family Therapy (45 min.)	$150
Group Therapy (60-75 min.)	$70

Specialized Evaluations

Report Writing	$75
Couples Assessment & Feedback	$200-$250
Deposition/Court Testimony (includes travel and preparation) **TO BE PAID IN ADVANCE**	$300/hour Min. $900
No Show or Late Cancellation Fee (Must be paid prior to next scheduled appointment)	$50
Letter or Physician statement	$120/hour Min. $70
Telephone Calls (more than 5 minutes and nonemergency)	$120/hour Min. $30
Completion of Health/Disability Forms	$120/hour Min. $70
Returned Check Fee	$50

By signing below, I acknowledge that I have read and understand this financial agreement.
I hereby request that payment of authorized insurance benefits (including Medicare), if **I** am a services beneficiary, be made on my behalf to **HMG Psychiatric Associates, P.C.** for any services provided to me by **HMG. I** authorize the release of any medical or other information by **HMG** necessary to process my claims. **I** understand that **I** am financially responsible for any charges that are not covered by my insurance.

Responsible Party Signature: _____ **Date**_____

Responsible Party Name (Print): _____

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

Relationship to Patient: _____

Responsible Party Address: _____

PSYCHIATRIC ASSOCIATES

Authorization to Release Information

In accordance with HIPAA privacy laws, a signed consent form is required to release information in any form about your care. This authorization allows us to communicate when needed or requested regarding scheduling, insurance or billing information, as well as routine or emergency contact. This authorization may be rescinded or amended at any time that you choose.

Please use the space below to identify any persons with whom you may want us to have contact.

I, _____, certify that I am 18 years old or older and give permission for HMG PSYCHIATRIC ASSOCIATES to communicate with the following persons about my treatment:

Name	Relationship	Phone
1)		
2)		
3)		
4)		

_____ **No Authorization to Release Information to any Nonprofessionals**
Please Check

_____ _____ _____

Print Patient's Name **Signature of Patient** **Date**

Psychiatric Intake Form
(All information on this form is strictly confidential)

Please complete all information on this form and bring it to the first visit. It may seem long, but most of the questions require only a check, so it will go quickly. You may need to ask family members about the family history. Thank you!

Name_____Date _____

Date of Birth_____Primary Care Physician_____

Current Therapist/Counselor_____Therapist's Phone_____

What are the problem(s) you are seeking help for?
1. _____
2. _____
3. _____

What are your treatment goals?

_____

_____

_____

Current Symptoms Checklist: (check once for any symptoms present, twice for major symptoms)

( ) Depressed mood	**( ) Racing thoughts**	**( ) Excessive worry**
( ) Unable to enjoy activities	**( ) Impulsivity**	**( ) Anxiety attacks**
( ) Sleep pattern disturbance	**( ) Increase risky behavior**	**( ) Avoidance**
( ) Loss of interest	**( ) Increased libido**	**( ) Hallucinations**
( ) Concentration/forgetfulness	**( ) Decrease need for sleep**	**( ) Suspiciousness**
( ) Change in appetite	**( ) Excessive energy**	**( ) _____**
( ) Excessive guilt	**( ) Increased irritability**	**( ) _____**
( ) Fatigue	**( ) Crying spells**	
( ) Decreased libido		

Suicide Risk Assessment
Have you ever had feelings or thoughts that you didn't want to live?
( ) Yes ( )No.
If YES, please answer the following. If NO, please skip to Past Psychiatric History
Do you **currently** feel that you don't want to live? ( ) Yes ( ) No
How often do you have these thoughts? _____
When was the last time you had thoughts of dying? _____
Has anything happened recently to make you feel this way? _____
On a scale of 1 to 10, (ten being strongest) how strong is your desire to kill yourself currently? _____
Would anything make it better?
_____
Have you ever thought about how you would kill yourself? _____ _____
Is the method you would use readily available? _____
Have you planned a time for this? _____
Is there anything that would stop you from killing yourself? _____

Do you feel hopeless and / or worthless? _____

Have you ever tried to kill or harm yourself before? _____

Your Medical History:

Allergies_____ Current Weight_____ Height _____

List ALL current prescription medications and how often you take them: (if none, write none)

Medication Name	Total Daily Dosage	Estimated Start Date

Current over-the-counter medications or supplements:_____

_____

Current medical problems:_____

_____

Past medical problems, nonpsychiatric hospitalization or surgeries_____

_____

Have you ever had an EKG? ( ) Yes ( ) No If yes, when_____ Was the EKG ( ) normal ( ) abnormal or ( ) unknown?

For women only: Date of last menstrual period_____ Are you currently pregnant or do you think you might be pregnant? ( ) Yes ( ) No. Are you planning to get pregnant in the near future? ( ) Yes ( ) No

Birth control method _____

How many times have you been pregnant?_____ How many live births? _____

Do you have any concerns about your physical health that you would like to discuss with me? ( ) Yes ( ) No

Date and place of last physical exam: _____

Personal and Family Medical History:

	You	Family	Which Family member
Thyroid Disease ----------	( )	( )	_____
Anemia----------	( )	( )	_____
Liver Disease ----------	( )	( )	_____
Chronic Fatigue ----------	( )	( )	_____
Kidney Disease ----------__	( )	( )	_____
Diabetes ----------	( )	( )	_____
Asthma/respiratory problems ----------	( )	( )	_____
Stomach or intestinal problems ----------	( )	( )	_____
Cancer (type) ----------	( )	( )	_____
Fibromyalgia ----------	( )	( )	_____
Heart Disease ----------	( )	( )	_____
Epilepsy or seizures ----------	( )	( )	_____
Chronic Pain ----------	( )	( )	_____
High Cholesterol ----------	( )	( )	_____
High blood pressure----------	( )	( )	_____
Head trauma ----------	( )	( )	_____
Liver problems----------	( )	( )	_____
Other----------	( )	( )	_____

Family Psychiatric History

Has anyone in four family been diagnosed with or treated for:

Bipolar disorder

Depression

Anxiety
Anger
Suicide
If yes, who had what problems?_____

Has any familiar member been trated with psychiatric medication? ( ) Yes ( ) No . If yes, who was treated and what medication and how effective was the treatment?

Is there any additional personal or family medical history? ( ) Yes ( ) No If yes, please explain

When your mother was pregnant with you, were there any complications during the pregnancy or birth?

Past Psychiatric History
Outpatient treatment ( ) Yes ( ) No If yes, Please describe when, by whom, and nature of treatment.
Reason Dates treated By whom

Psychiatric Hospitalization ( ) Yes ( ) No If yes, describe for what reason, when and where.
Reason Date Hospitalized Where

Past Psychiatric Medications: If you have ever taken any of the following medications, please indicate the dates, dosage, and how helpful they were (if you can't remember all the details, just write in what you do remember).

Dates Dosage Response/Side-Effects

Antidepressants
Prozac (fluoxetine)_____
Zoloft (sertraline)_____
Luvox(fluvoxamine)_____
Paxil (paroxetine)_____
Celexa(citalopram)_____
Lexapro(escitalopram)_____
Effexor (venlafaxine)_____
Cymbalta (duloxetine)_____
Wellbutrin (bupropion)_____
Remeron(mirtazapine)_____
Serzone(nefazodone)_____
Anafranil(clomipramine)_____
Pamelor (nortrptyline)_____
Tofranil (imipramine)_____
Elavil(amitriptyline)_____
Other_____
Mood Stabilizers
Tegretol (carbamazepine)_____
Lithium_____

Depakote (valproate)_____
Lamictal (lamotrigine)_____
Tegretol (carbamazepine)_____
Topamax(topiramate)_____
Other_____

Past Psychiatric medications (continued)

Antipsychotics/Mood Stabilizers

Seroquel (quetiapine)_____
Zyprexa (Iolanzepine)_____
Geodon (ziprasidone)_____
Abilify (aripiprazole)_____
Clozaril (clozapine)_____
Haldol (haloperidol)_____
Prolixin (fluphenazine)_____
Other

Sedative/Hypnotics

Ambien (zolpidem)_____
Sonata(zaleplon)_____
Rozerem (ramelteon)_____
Restoril (temazepam)_____
Desyrel (trazodone)_____
Other_____

ADHD medications

Adderall (amphetamine)_____
Concerta(methylphenidate)_____
Ritalin(methylphenidate)_____
Strattera (atomoxetine)_____
Other

Antianxiety medications

Xanax (alprazolam)_____
Ativan (Iorazepam)_____
Klonopin (clonazepam)_____
Valium (diazepam)_____
Tranxene (clorazepate)_____
Buspar (buspirone)_____
Other_____

Your Exercise Level:

Do you exercise regularly? ( ) Yes ( ) No
How many days a week do you get exercise?_____
How much time each day do you exercise?_____
What kind of exercise do you do?_____

Family Psychiatric History:

Has anyone in your family been diagnosed with or treated for:

Bipolar disorder	( ) Yes	( ) No	Schizophrenia	( ) Yes	( ) No
Depression	( ) Yes	( ) No	Post-traumatic stress	( ) Yes	( ) No
Anxiety	( ) Yes	( ) No	Alcohol abuse	( ) Yes	( ) No
Anger	( ) Yes	( ) No	Other substance abuse	( ) Yes	( ) No
Suicide	( ) Yes	( ) No	Violence	( ) Yes	( ) No

If yes, who had what problems?_____

_____

Has any family member been treated with a psychiatric medication? ( ) Yes ( ) No If yes, who was treated and what medications and how effective was the treatment?_____

_____

Substance Use:

Have you ever been treated for alcohol or drug use or abuse? ( ) Yes ( ) No
If yes, for which substances?_____
If yes, where were you treated and when?_____

_____

How many days per week do you drink any alcohol?_____
What is the least number of drinks you will drink in a day? _____
What is the most number of drinks you will drink in a day?_____
In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day?_____
Have you ever felt you ought to cut down on your drinking or drug use? ( ) Yes ( ) No
Have people annoyed you by criticizing your drinking or drug use? ( ) Yes ( ) No
Have you ever felt bad or guilty about your drinking or drug use? ( ) Yes ( ) No
Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? ( ) Yes ( ) No
Do you think you may have a problem with alcohol or drug use? ( ) Yes ( ) No
Have you used any street drugs in the past 3 months? ( ) Yes ( ) No
If yes, which ones?_____
Have you abused prescription medication? ( ) Yes ( ) No
If yes, which ones and for how long_____

Check if you have ever tried the following:

	Yes	No	If yes, how long and when did you last use?
Methamphetamine	( )	( )	_____
Cocaine	( )	( )	_____
Stimulants (pills)	( )	( )	_____
Heroin	( )	( )	_____
LSD or Hallucinogens	( )	( )	_____
Marijuana	( )	( )	_____
Pain killers (not as prescribed)	( )	( )	_____
Methadone	( )	( )	_____
Tranquilizer/sleeping pills	( )	( )	_____

Alcohol ( ) ( ) _____

Ecstasy ( ) ( ) _____
Other ( ) ( ) _____

How many caffeinated beverages do you drink a day? Coffee_____ Sodas_____ Tea_____

Tobacco History
How you ever smoked cigarettes? ( ) Yes ( ) No
Currently? ( ) Yes ( ) No. How many packs per day on average? _____ How many years?_____
In the past? ( ) Yes ( ) No. How many years did you smoke?_____ When did you quit? _____

Pipe, cigars, or chewing tobacco: Currently? ( ) Yes ( ) No. In the past? ( ) Yes ( ) No
What kind? _____ How often per day on average?_____ How many years? _____

Family Background and Childhood History:
Were you adopted? ( ) Yes ( ) No Where did you grow up?_____
List your siblings and their ages:_____
_____
What was your father's occupation?_____
What was your mother's occupation _____
Did your parents' divorce? ( ) Yes ( ) No Ifso, how old were you when they divorced?_____
If your parents divorced, who did you live with?_____
Describe your father and your relationship with him:_____
_____
Describe your mother and your relationship with her: _____
_____
How old were you when you left home?_____
Has anyone in your immediate family died? _____
Who and when?_____
Trauma History:
Do you have a history of being abused emotionally, sexually, physically or by neglect? ( ) Yes ( ) No.
Please describe when, where and by whom._____
_____

Educational History:
Did you attend college?_____ Where?_____
Major?_____
What is your highest educational level or degree attained?_____
Occupational History:
Are you currently: ( ) Working ( ) Not working by choice ( ) Unemployed ( ) Disabled ( ) Retired
How long in present position? _____
What is/was your occupation?_____
Where do you work?_____
Have you ever served in the military?_____ If so, what branch and when?_____

Honorable discharge( ) Yes ( ) No Other type discharge_____

Relationship History and Current Family:
Are you currently: ( ) Married ( ) Divorced ( ) Single ( ) Widowed
How long?_____
If not married, are you currently in a relationship? ( ) Yes ( ) No If yes, how long?_____
Are you sexually active? ( ) Yes ( ) No
How would you identify your sexual orientation?
( ) straight/heterosexual ( ) lesbian/gay/homosexual ( ) bisexual ( ) transsexual
( ) unsure/questioning ( ) asexual ( ) other ( ) prefer not to answer
What is your spouse or significant other's occupation?_____
Describe your relationship with your spouse or significant other:
_____
_
Have you had any prior marriages? ( ) Yes ( ) No. If so, how many?_____
How long? _____
Do you have children?( ) Yes ( ) No. If yes, list ages and gender_____
_____
Describe your relationship with your children:_____
List everyone who currently lives with you? _____
Legal: Have you ever been arrested?_____ Do you have any pending legal problems?_____

Spiritual life
Do you belong to a particular religion or spiritual group? ( ) Yes ( ) No
If yes, what is the level of your involvement? _____
Do you find your involvement helpful during this illness, or does the involvement make things more difficult or stressful for you? ( ) more helpful ( ) stressful
Is there anything else that you would like Dr. to know?
_____
_____
_____

Signature_____ Date_____

HMG Psychiatric Associates, P.C.

AUTHORIZATION TO DISCLOSE CONFIDENTIAL INFORMATION

Consumer's Full Name	Social Security Number	Date of Birth

I hereby authorize: _____
Name of Person or Organization Phone # Fax #

_____
Street Address City State Zip

to use/disclose/exchange the following healthcare information and records: (Check all that apply)

☐ Intake/Referral ☐ Diagnosis ☐ Treatment Plan ☐ Evaluation/Assessment ☐ Psychological Evaluation
☐ Physical Health ☐ Medications ☐ Progress Notes ☐ Discharge Summary ☐ Summary of Services Received
☐ Social History ☐ Transportation ☐ Financial ☐ Employment ☐ Title IV-E Eligibility
☐ Participation & Attendance ☐ Substance Abuse ☐ Infectious Diseases: AIDS, HIV, TB
Other: _____

To/With: _____
Name of Person or Organization Phone # Fax #

_____
Street Address City State Zip

Purpose of use/disclosure/exchange of information is: (Check all that apply) ☐ Assessment ☐ Treatment ☐ Discharge Planning ☐ Benefits/Service Eligibility ☐ Coordination of care ☐ Legal ☐ Other: _____

Dates of Service for Information: (If a specific time period is needed or known): _____/_____/_____to _____/_____/_____

As the person signing this authorization, I understand that I am giving my permission to the above-named health care entity for disclosure of confidential health records. I want all persons and organizations to accept a copy or faxed version of this form as a valid authorization to share information. If I do not sign this form, information will not be shared and I will have to contact each agency individually to give them information about me that they need. I understand that:

- HMG Psychiatric Associates, PC cannot condition treatment or payment on my willingness to sign this authorization. I may refuse to sign this authorization.
- This authorization will become effective upon the date signed below unless noted otherwise.
- Only the information needed to satisfy the stated purpose of this disclosure will be shared. I understand this will include information added alter the authorization origination date and up until the authorization expiration date.
- I have the right to revoke this authorization at any time, except to the extent that action has been taken in reliance on it, by delivering the revocation in writing to the provider who is in possession of my health care records. (Use "Revocation of Authorization to Disclose Confidential Information" (HIPAA 008)).
- A copy of this authorization and a notation concerning the persons or agencies to whom disclosure was made shall be included with my original health records.
- There is a potential for any information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and, therefore, no longer protected by the provisions of the HIPAA Privacy Rule. If this information is being disclosed from records protected by the Federal substance abuse confidentiality rules (42 CFR Part 2), the Federal rules prohibit the recipient from making any further disclosure of this information unless further disclosure is expressly permitted by your written authorization or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.
- HMG Psychiatric Associates, PC, its employees and Board, are hereby released from any legal responsibility or liability for disclosing information as I have authorized by completing this form, or for the use of information by the person or organization receiving it.

Unless revoked, this authorization will expire: ☐ in 365 days (one year) ☐ Other (specify date or event): _____

_____
Consumer's signature Date

_____
Parent/Guardian/Authorized Representative's signature, when required Date

_____
Witness signature optional, unless consumer's signature is a "mark" Date

HIPAA 004

☐ **Copy Provided to Consumer** ☐ **Consumer Refused Copy**
(Check applicable box)

Latest Rev. 6/12
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