

Anna R. Flynn, M.D.
Child, Adolescent & Adult Psychiatry

AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or a health care provider, that organization may also disclose my health information. If this happens, I understand that my information may no longer be protected by federal privacy regulations.

Patient name: _____

Persons/Organizations authorized to release and receive the information: _____

Specific description of information (including date(s)): _____

The patient and/or the patient's representative must read and initial the following statements:

1. I understand that this authorization will expire _____ Initials: _____

2. I understand that I may revoke this authorization at any time by notifying Dr. Flynn in writing. But, if I do revoke this authorization, my revocation will not have an effect on any actions Dr. Flynn took in reliance upon my authorization before it received my revocation. Initials: _____

You may revoke this authorization by signing a Revocation of Authorization form and returning it to Dr. Flynn. To request a Revocation of Authorization form, you may contact Dr. Flynn at the address above.

3. I understand that Dr. Flynn will not condition my treatment or payment for your health care services on your completing and signing this authorization. Initials: _____

Patient Name: *(Please Print)* _____

Printed name of patient's guardian (Patients 17 and younger): _____

Relationship to patient: _____

Signature of patient (Patients 12 years and older)

Signature of patient's guardian (Patients 17 and younger)

Date _____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.