

Manlove Psychiatric Group, P.C.

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Request for Release of Protected Health Information & Authorization

Today, (date) _____, I, _____, hereby request and

Authorize the following actions be taken for () myself, or my () son, () daughter, () _____

Named: (first) _____ (MI) _____ (last) _____ with _____
Other Legal Relationship

Date of Birth: ____/____/____ and/or Social Security: _____ - _____ - _____.

Release of Records: From and To: **Manlove Psychiatric Group, P.C. (MPG)**

Release of Records: To and From: _____
Name

Address – City – State – Zip - Telephone - Fax

I hereby request and explicitly authorize the mutual exchange of any and all MPG Protected Health Information and/or other similar records between both of the named parties, as indicated below, to be used in providing care or benefits. When the requested data and material is forwarded to MPG by your medical practitioner, this shall serve as your medical practitioner's consent in regard to releasing the requested information to Manlove Psychiatric Group, P.C., and to others as deemed necessary unless any objection thereto is received. I understand that I do not have to sign this form. Failure to do so may result in loss of care, eligibility or other benefits under certain circumstances.

This information shall include: Please initial only those items that apply....

___ Evaluations _____ Testing Reports _____ Aids or HIV antibody test results

___ Lab/Procedure Results _____ Letter _____ Appt. Info

___ Verbal/Phone _____ Other _____

___ All of the Above in All Columns _____ Verbal Exchange ONLY

I understand that my PHI may be protected under the federal regulations governing HIPAA and/or Confidentiality of Alcohol and Drug Abuse Patient Records, 42CFR Part 2, and cannot be disclosed without my written authorization unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time, except to the extent those actions have been taken in reliance on it. This consent is in effect for two years from date signed by the patient or legal guardian, unless revoked.

It is very important for you to know that some things, by law, cannot be kept private. These are the exceptions to confidentiality, including but not limited to: If we are ordered to testify in or provide documents to a Court of Law, we may have to give information regarding your case without your permission. If we learn that harm has been done to a child or an elderly person, we may be required to inform the authorities. If we learn that someone or something might be seriously harmed in the future, or that a patient intends to commit an act of violence, it may be our responsibility to protect you, or others, by informing them and the authorities. MPG prohibits the re-release of our records by a third party. It is possible, however, that pursuant to the authorized release of records, that the third party, without our knowledge, may release those records to a fourth party. In this situation, the records may no longer be protected by HIPAA.

This release may be copied/faxed for use with the full force and effect of the original. I understand that I have a right to receive a copy of this authorization and the PHI released upon my request. If you have further questions, please consult the *MPG Notice of Information Practices* or information concerning your rights. I must contact MPG to obtain the necessary form to revoke this authorization.

I certify that I understand the above information and believe myself to be legally competent and authorized to execute this authorization.

Signature of Patient or Legal Guardian: _____ Date: _____

(If Legal Representative has signed, a verifiable copy of the Court Order MUST be attached for Request to be valid.)

Witness: _____ Date: _____

Witness signature line MUST be legibly signed for authorization to be valid.

Received by MPG on _____ by _____ Release #: _____

Revised 20090327

For MPG Use Only:

Failure to Obtain Authorization

Check the appropriate reason:

- Indirect treatment relationship
- Substantial Barriers in Communication
- Verbal Request (at least 2 signatures required)
- Release Required by Law
- Other

Description of Circumstances:

Staff Signature: _____ Date: _____

Witness: _____ Date: _____

Witness: _____ Date: _____