AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Send Records To: **Anavota Behavioral Health PLLC**
Mailing: 6666 Harwin Drive Suite 155, Houston TX, 77036
Main office: 877-895-5486 Fax: 608-305-8664
Other Phone: 832-834-3830

This form allows us to gather your past history so we have a full picture of what you have tried which will help us give you the best level of care. Your doctor will be able to make a better treatment plan, and we will be better able to get insurance to cover your treatment options. **Please fill out one form for each doctor who has prescribed medication and/or any therapists.**

FOR:

Patient Name:_____ Date of Birth: _____

Address:_____

Phone: _____

REQUEST RECORDS FROM:

Name of Provider or Facility: _____

Address:_____

Phone:_____ Fax: _____

Specific description of the information to be disclosed:

- ☑ Full medical record
- ☑ Medication Consent
- ☑ Psychiatric Evaluation
- ☑ Progress Notes
- ☑ Genetic testing
- ☑ Treatment Plan
- ☑ Psychological Testing
- ☐ Phone contact
- ☐ Billing reports
- ☑ Lab Report
- ☑ Discharge Summary
- ☑ Demographics
- ☐ Other:

Specific description of the purpose of the disclosure:

- ☑ Continued patient care
- ☐ Other (specify):
- ☐ Disclosure at patient request

By signing below, I authorize the provider to use or disclose information related to:
Behavioral Health care/Psychiatric Care, Insurance Coverage (COB), and I consent to the release of information created within 12 months before/after the date this authorization was signed

I understand my treatment is not conditional on signing this authorization. I may refuse to sign this authorization form. I may revoke this authorization at any time, unless the disclosing party has already relied on my authorization to disclose health information. To revoke my authorization, I must submit a written request to Serenity. If I do not revoke this authorization earlier, it will expire one year from the date of signature. I understand that if this information is disclosed to a third party, the information may no longer be protected by the federal privacy regulations and may be re- disclosed by the person/organization that receives the information. I understand the matters discussed on this form. I release the provider, its employees, officers and directors, medical staff members and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

_____ _____
Signature of Patient/Legal Guardian Date

If you are not the patient, but are signing on behalf of the patient, please complete the following:

_____ _____
Printed name Relationship to patient (Legal guardian ONLY) Attach a copy of court documents if applicable.