TRUENORTH PSYCHIATRIC NURSING CORP
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AUTHORIZATION FOR RELEASE / EXCHANGE

Authorization for Release / Exchange of Health Information

This authorization allows TrueNorth to obtain, disclose, or exchange only the information you select below.

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____

Phone: _____ Email: _____

PERSON / ORGANIZATION AUTHORIZED TO EXCHANGE INFORMATION

Name / Organization: _____

Relationship / Role: _____ Phone: _____ Fax: _____

Address: _____

Email (if applicable): _____

I authorize:

- ☐ TrueNorth to RELEASE information to the person/organization above
- ☐ TrueNorth to OBTAIN information from the person/organization above
- ☐ TWO-WAY exchange of information between TrueNorth and the person/organization above

INFORMATION AUTHORIZED

Check only the information you authorize:

- ☐ Psychiatric evaluations / diagnoses
- ☐ Medication list / medication management
- ☐ Progress notes
- ☐ Laboratory / diagnostic results
- ☐ Treatment plans / summaries
- ☐ Billing / insurance
- ☐ Entire record, except information requiring additional specific authorization
- ☐ Other: _____

SENSITIVE INFORMATION - SPECIFIC AUTHORIZATION

California and federal law may provide additional protection to certain information. Check each category you specifically authorize:

- ☐ Substance-use-disorder treatment information, when legally permitted
- ☐ HIV/AIDS-related information
- ☐ Sexually transmitted infection information
- ☐ Genetic testing information
- ☐ Other specially protected information: _____

PURPOSE

- ☐ Coordination of care
- ☐ At my request
- ☐ Insurance / benefits
- ☐ Legal
- ☐ Other: _____

EXPIRATION & REVOCATION

This authorization expires (choose one):

- ☐ 12 months from signature
- ☐ On this date: _____
- ☐ Upon this event: _____

I understand that I may revoke this authorization at any time by notifying TrueNorth in writing, except to the extent action has already been taken in reliance on it. Treatment, payment, enrollment, or eligibility for benefits generally will not be conditioned on signing this authorization except where permitted by law. Information disclosed under this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA; however, other federal or California confidentiality laws may continue to restrict redisclosure. A copy or electronic copy of this authorization is as valid as the original.