Kelley M. Starling, MD, PLLC

AUTHORIZATION FOR RELEASE OF MENTAL HEALTH INFORMATION

(also known as Protected Health Information)

Patient Name: _____

Patient Address: _____

Date of Birth: _____ Phone: _____ Last 4 of SSN: _____

I. My Authorization. I authorize the use or disclosure of the above individual's protected health information as described below for coordination of care between my providers. My psychiatric provider or provider representative at Kelley M Starling, MD PLLC is authorized to disclose information to my current provider or their representative that is listed below. My provider or their representative are authorized to disclose protected information to my psychiatric provider or their representative at Kelley M Starling, MD PLLC.

Provider Name	Provider Address	Provider Phone Number	Provider Fax Number
_____	_____	_____	_____

Practice Name	Practice Address	Practice Phone Number	Practice Fax Number
Kelley M Starling, MD PLLC	1616 South Voss Rd., Suite 625, Houston, TX 77057	(713) 543-0063	(713) 347-0943

The type of information to be used or disclosed is as follows (SELECT ALL THAT APPLY):

☐ Complete treatment records ☐ Demographic Information

☐ Diagnosis and current mental status ☐ Medication Lists / Medications Prescribed

Any specific Information that you do not want shared between providers?

_____

This authorization ends:

☐ - On (date): One year from this form date ☐ - When the following event occurs:

_____

II. My Rights

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance information. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study), and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it if requested. A copy of this authorization is as valid as the original.

_____ (initials) III. Additional Consent for Certain Conditions

This medical record may contain information about **physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment**. Separate consent must be given before this information can be released.

○ I consent to have the above information released. ○ I do not consent to have the above information released.

_____ (initials) IV. Additional Consent for HIV/AIDS

This medical record may contain information concerning **HIV testing and/or AIDS diagnosis or treatment**. Separate consent must be given to have this information released.

○ I consent to have the above information released. ○ I do not consent to have the above information released.

If the patient is a minor or unable to sign, please complete the following:

☐ - Patient is a minor: _____ years of age ☐ - Patient is unable to sign because:

_____

Printed Name of Authorized Representative: _____

Authority of representative to sign on behalf of the patient:

☐ - Parent ☐ - Legal Guardian ☐ - Court Order ☐ - Other: _____

Signature of Patient / Legal Guardian / Parent:

_____ Date: _____