Mackay Behavioral Health services

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mackaybehavioralhealthservices@gmail.com

Patient Name: _____DOB: _____ The person named above hereby authorizes _____(requesting provider) to: ☐ Request Health Information from ☐ Send Information to ☐ Discuss Information with The person named above authorizes information to be requested or released by representatives of: Name of Person, Provider or Facility:_____ Address: _____ _____ Phone: _____ Fax: _____

Specific Health Information Authorized: ☐ I authorize disclosure of my health information, including information relating to medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information; or ☐ I authorize only the disclosure of the following information:_____ Specific Health Information Requested (Requesting Provider to fill out): ☐ Medication List ☐ Last Physical Exam, Medical Problem List ☐ Laboratory results from past 12 months ☐ Diagnostic Test Results (ECG, MRI, CT, Sleep Study, EEG) ☐ Last Visit Summary (Incl. Current Meds & Dx) ☐ Past Psychiatric Evaluation ☐ Hospital Discharge Summary ☐ Clinical Notes/Assessments ☐ Psychological/ Neuropsychological Testing ☐ Other: _____

I understand and agree that: • This authorization is voluntary; My health information may contain information created by other persons or entities including health care providers and may contain medical, pharmacy, dental, vision, mental health, substance abuse, HIV/AIDS, psychotherapy, reproductive, communicable disease and health care program information; • I understand that I may refuse to sign or may revoke (at any time) this authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of my treatment by my health care provider, except to the extent that the information being requested may assist your health care provider in determining appropriate treatment. • My health information may be subject to re-disclosure by the recipient, and if the recipient is not a health plan or health care provider, the information may no longer be protected by the federal privacy regulations. • This authorization will expire one year from the date I sign the authorization. I may revoke this authorization at any time by notifying my provider in writing; however, the revocation will not influence any actions taken prior to the date my revocation is received and processed. Signature:_____Date: _____ Relationship, if not Patient:

_____

Provider: Dr. Angela Mackay DNP CRNP-PMH APRN MSN PHN BSN RN