

RANDALL V. SELLERS, MD

GENERAL PSYCHIATRY *
CHILD & ADOLESCENT PSYCHIATRY *
FORENSIC PSYCHIATRY *
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AUTHORIZATION for the use or disclosure of Protected Health Information:

(Patient Name) (Date of birth)

I HEREBY FREELY AND VOLUNTARILY AUTHORIZE RANDALL V SELLERS MD TO:

(CHECK ONE) _____ **RELEASE / DISCLOSE RECORDS OF MY HEALTH INFORMATION TO:**
_____ **OBTAIN RECORDS OF MY HEALTH INFORMATION FROM:**

(Individual, Facility, Organization) (Telephone #) (Fax #)

(Address) (City, State, Zip)

The purpose of the release of this data shall be:

- 1) further health care 2) treatment planning / coordination 3) educational planning 4) at my request

The information to be released includes:

Medical Record	Hospital Records:
Psychotherapy Records	Admission Psychiatric Evaluation
Psychological Testing	History and Physical
Academic Records / Classroom Observations	Psychological Testing
Verbal Exchange of Information	Laboratory Tests, EEG, EKG
Other:	Discharge Summary

My medical and psychotherapy records may include information regarding testing, diagnosis and treatment of mental health, drug, alcohol, acquired immune deficiency syndrome (AIDS), hepatitis B, venereal disease, tuberculosis, and other communicable diseases. I understand that such information is confidential and is protected by federal law. I understand that the provision of health care treatment to me cannot be conditioned upon my agreement to sign an authorization for the disclosure or use of my health information for purposes other than for treatment, payment and health care operations. I understand that the potential exists for the health information that is released with my authorization to be re-disclosed by the recipient, and to be no longer protected by the federal HIPAA Law.

I understand that I have the right to revoke this authorization at any time by giving written notice to Randall V Sellers MD, except to the extent that Dr. Sellers has already taken action in reliance on it. This authorization will expire in 180 days or as otherwise specified herein: _____; whichever come first.

Patient signature (patient must sign regardless of age if alcohol / drug treatment is involved) (date)

Parent / Guardian / if Authorized Representative (describe: _____) (date)

Witness (date)