BEYOND PSYCHIATRY BEHAVIORAL HEALTH
150 E Medical Center Blvd, Suite A. Webster, TX.77598
Phone: 281-481-4646 Fax: 281.481-4649
www.beyondpsychiatry.com

HIPAA Request Form to Receive Information

PATIENT INFORMATION

DATE: _____

Name:_____DOB: _____

Address_____City_____State____ZIP_____

Information to be disclosed (Type of Request)

☐ Entire record ☐ Psychiatry Initial Evaluation ☐ Progress Notes

☐ Therapy Notes ☐ Labs ☐ Billing Reports

☐ Verbal Consent – Relationship to Patient: _____

Purpose of Disclosure:

☐ Continuity of Care ☐ Patient/Guardian request ☐ Disability/ FMLA

☐ Attorney Requests ☐ Other (Please Specify) _____

RECEIVE FROM or RELEASE TO: (Circle One)

Name of Organization/Person: _____

Address: _____

Phone:_____Fax: _____

Right to Terminate or Revoke Authorization: You have the right to revoke or terminate the authorization of your PHI in in writing to Beyond Psychiatry Behavioral Health.

Potential for Re-Disclosure: Information that is disclosed for this authorization might be disclosed again by the person or organization in which the information is intended for. Beyond Psychiatry Behavioral Health cannot ensure protection of your PHI once it is disclosed to another party.

Individual Rights: You have the right to review or copy the information used or disclosed under this authorization. You can refuse to sign this authorization, if you do not agree with what information is being disclosed.

Refusing Release of PHI: If you refuse to sign this release of your PHI, Beyond Psychiatry Behavioral Health will not deny any services or treatments.

Print Name: _____ Phone No :_____

Date: _____

Signature: _____