SUFFOLK BEHAVIORAL MEDICINE P.C.
Authorization for the Release of Protected Health Information

Name of patient: _____ Date of Birth: _____
Address:_____
_____

Type of Release of Authorization:

____I authorize Suffolk Behavioral Medicine PC and Dr. Mulchand Chugh to release all protected health information to and from:

_____
_____
_____
_____
_____

(Name, address, phone number, and fax if applicable)

Extent of Nature of information to be disclosed, including dates of treatment or hospital:

__Complete Record, __Discharge summary, __Progress notes, __Laboratory tests
__Diagnostic Testing, __Consultation reports, __Outpatient Visit, __ Others

Purpose or need for the disclosure:
__ Attorney, __Insurance, __Medical Care, __Personal, __Other

I understand that I may withdraw this consent at any time, either verbally or in writing except to the extent that action has been taken in reliance on it. This consent will last while I am being treated for Opioid dependence by the physician specified above unless I withdraw my consent during treatment. This consent will expire 365 days after I complete my treatment, unless the physician specified above is otherwise notified by me.

I understand that the records to be released may contain information pertaining to psychiatric treatment and/or treatment for alcohol and/or drug dependence. These records may also contain confidential information about communicable diseases including HIV (AIDS) or related illness. I understand that these records are protected by the Code of Federal Regulations Title 42 Part 2 (42 CFR Part 2) which prohibits the recipient of these records from making any further disclosures to third parties without the express written consent of the patient.

I acknowledge that I have been notified of my rights pertaining to the confidentiality of my treatment information/records under 42 CFR Part 2, and I further acknowledge that I understand those rights.

_____ _____ _____
Signature of patient or personal representative or legal guardian Relationship to patient Today's date

_____ _____ _____
Print name if other than patient Today's Date Relationship to patient

_____ _____ _____
Address and tel of patient or representative Signature of witness Today's Date