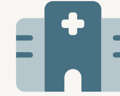
Talkiatry

Phone: 833-351-8255
Fax: 888-815-3583
hello@talkiatry.com

109 W 27th Street Suite 5S,
New York, NY 10001

Authorization to obtain medical information pursuant to HIPAA



Use this form if you would like an external healthcare provider to disclose your protected health information (PHI)/medical records to Talkiatry for the purposes of continuity of care. This is allowing Talkiatry to have access to your protected health information (PHI)/medical records from another healthcare entity outside of Talkiatry.

Please complete all details in this form, sign it, and provide it to Talkiatry and to your non-Talkiatry healthcare provider. Your Talkiatry clinician will reach out to the external healthcare provider indicated in this form.

(Please note some healthcare providers or facilities require a fee in order to release medical records. This fee, if applicable, will be the patient's responsibility to the extent permitted by law).

Patient details

Name ______________________ Date of birth ______________

Address ______________________ State ________ Zip Code ______________

Email address ______________________

Parent or legal guardian of patient (if applicable)

Name ______________________ Date of birth ______________

Address ______________________ State ________ Zip Code ______________

Email address ______________________

By completing, signing and submitting this form, I request and authorize the below person/entity to release my protected health information to Talkiatry, represented by MCCD Psychiatry Services PLLC, and all members of its affiliated covered entity (collectively "MCCD Psychiatry Services") for the purposes of continuity of care.

Person/entity to release PHI to Talkiatry

Individual Name (if applicable) ______________________

Institution name (if applicable) ______________________

Address ______________________ State ________ Zip Code ______________

Phone ______________ Fax ______________ Email address ______________________

Methods of transmission of PHI

Verbal exchange of PHI

Email transmission of PHI (*send to hello@talkiatry.com*)

Fax transmission of PHI (*fax to 888-815-3583*)

Mailed hard copies of PHI (*mail to Talkiatry, Medical Records Dept., 109 W 27th St, Suite 5S, New York NY 10001)*

Note to external healthcare provider disclosing PHI to Talkiatry: Please only supply records via phone call, email, fax or mailed hard copy. Please DO NOT supply electronic records on external media (CD, DVD, USB thumb drive, etc). Any records received on such media cannot be accessed and will be returned.

Protected health information to be released

I authorize the following information to be released:

Entire health record, including patient histories, progress notes, test results, referrals, consults, insurance records and the sensitive information listed below, **for all dates of service**.

OR

Entire health record, including patient histories, progress notes, test results, referrals, consults, insurance records and the sensitive information listed below, **for only the following date range**:

Start date: ______________________

End date: ______________________

OR

Other (please specify) ______________________

____

Sensitive information:
Please **uncheck** the box next to any sensitive material you **do not** wish to be released:

Substance abuse, diagnosis or treatment

Mental health information, including psychiatric clinical records

HIV/AIDS testing, status, diagnosis and treatment

STI testing, diagnosis or treatment

Genetic testing information

Biometric information

Reproductive or sexual health application information

Billing records

Expiration of authorization

This authorization is valid and will expire **one year** after the date of signing, **unless formally withdrawn earlier by the patient.**

Withdrawal of authorization

This authorization may be withdrawn at any time by submitting a written request to the person or entity releasing PHI. Withdrawal of this request may not affect any authorized action taken place prior to receipt of a written request to withdraw authorization.

Signature and authorization

PHI released may contain sensitive information as authorized above. Talkiatry, MCCD Psychiatry Services and many other organizations and individuals such as doctors, healthcare facilities and health insurance plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to an individual or entity who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

I have read and understand the information in this authorization.

Signature of patient or authorized representative ______________________ Date ____________

If signed by authorized representative, relationship to patient: ______________________

Printed name of authorized representative ______________________