CHARLES P. GENNAULA, M.D.

Specializing in Neurology

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AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Name of Patient _____
Date of Birth _____ SS# _____
Daytime Phone # _____ Evening Phone # _____
Address _____
City _____ State _____ Zip Code _____

I hereby authorize _____ to use or disclose my protected health information as indicated below to:

Name _____
Daytime Phone # _____ Fax # _____
Address _____
City _____ State _____ Zip Code _____

Information to be released:
From & To Dates _____
___ History & Physical Exam
___ Lab Report
___ X-ray report
___ Consultation report _____
___ Other _____

Purpose of Disclosure:
___Changing MD's ___2nd Opinion
___Continuing Care ___Legal
___At my (patient) request ___Insurance
___Workers' Compensation ___School
___Other _____

I understand that this health information may include HIV-related information and/or information relating to diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by signing this form, I am specifically authorizing the release of information relating to:

___ Substance Abuse (including alcohol/drug abuse)
___Mental Health
___Psychotherapy Notes
___HIV related information (including AIDS related testing)

The confidentially of this record is required under Chapter 899 of the Connecticut General Statues, as well as, Title 42 of the United States code. This material shall not be transmitted to anyone without written consent or authorization as provided in these statutes.

X _____ _____
Signature of Patient or Legal Guardian Date

1. I understand that this authorization will expire one year from my last date of service visit. A photocopy of this form will be considered as valid as the original.
2. I understand that I may revoke this authorization at any time by notifying Kelly Olexik, Privacy Officer, at the address indicated below, in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it: Charles P. Gennaula, M.D./Pushpa Kumari, M.D.; 100 Peasant Village Lane; Belle Vernon, PA 15012
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS-related information, and psychiatric/mental health information.
4. My health care and payment for my health care will not be affected if I do not sign this form.
5. I understand that my refusal to sign this Authorization will not jeopardize my right to obtain present or future treatment for psychiatric disabilities except where disclosure of the information is necessary for the treatment.
6. I understand that I will get a copy of this form after I sign it.

By signing below, I acknowledge that I have read and understand this Authorization.

_____ _____ OR _____ _____
Signature of Patient Date Parent/Legal Guardian/Authorized Person Date

_____
Relationship to Patient

FOR OFFICE USE ONLY

Date Request Filled _____ By _____ Fee Collected _____