Discovery Therapeutic Services

Date-_____
Initial Eval: _____
Reviewed By:_____

HIPPA AUTHORIZATION TO RELEASE MEDICAL RECORDS & INFORMATION

This authorization expires 90 days from the date below and may be revoked by the patient orally or in writing at any time.

Last Name: _____ First Name: _____ Date of Birth: _____

Another name, if applicable: _____

Patient Address: _____

Phone Number: _____

REASON FOR REQUEST:_ _____ Changing Providers _____Legal Reasons _____Personal Use

Please send the following records:

- ☐ All Medical Records
- ☐ Medical Records from _____ to _____
- ☐ Records specifically pertaining to _____

I , _____, herby authorize ***DISCOVERY THERAPEUTIC SERVICES, LLC*** to release my medical records to _____. I understand that my records may contain information regarding the diagnosis or treatment of (HIVAIDS virus), other sexually transmitted diseases, drug and /or alcohol abuse, mental illness or psychiatric treatment. I give my specific authorization for these records to be released. If signing for a person over 18 years of age, proof of guardianship, power of attorney, or executor of estate must be provided.

I understand that the information used or disclosed under the Authorization From may be subject to re-disclosure by the person(s) or facility receiving it and would then no longer be protected by federal privacy regulations. I have the right to refuse to sign this Authorization Form. If signed, I have the right to revoke the authorization in writing , at any time. I understand that any action already taken in reliance on this authorization cannot be revered, and my revocation will not affect those actions.

_____ _____

Signature of Patient/Guardian Date

_____ _____

Print Name Date

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