Authorization to Release or Obtain Information

Interactive Psychiatry

Provider: Taimaris Mas Marante, PMHNP-BC

I, the undersigned, authorize Interactive Psychiatry and Taimaris Mas Marante, PMHNP-BC, to release or obtain the following protected health information:

☐ Psychiatric evaluation and diagnosis
☐ Progress notes and treatment summary
☐ Medication history and current prescriptions
☐ Laboratory results
☐ Other (specify): _____

This information may be released to or obtained from:

Name/Facility: _____
Address: _____
Phone: _____ Fax: _____
Relationship to patient: _____

Purpose of disclosure:
☐ Continuity of care
☐ Legal purposes
☐ Coordination with other providers
☐ Other: _____

I understand that:
- I have the right to revoke this authorization in writing at any time.
- Revocation will not apply to information already released.
- I may refuse to sign this form and it will not affect my treatment.
- Information disclosed may be subject to redisclosure and no longer protected by HIPAA.

This authorization will expire:
☐ In 1 year ☐ On this date: _____ ☐ Other: _____

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

Patient Name: _____

Signature: _____ Date: _____

Witness/Provider Signature: _____ Date: _____