Jeffrey M. Benzick, M.D., P.A.

General Adult Psychiatry and Sport Psychiatry

14800 San Pedro Avenue, Suite 110
San Antonio, TX 78232
Phone: (210) 490-9850 FAX: (210) 490-1465

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I, _____, date of birth _____, authorize the release of my protected health information only in the specific manner outlined below (check all that apply).

□ Dr. Benzick may **obtain** information from another health care provider or family member:

Name of Provider or Family Member: _____
Phone Number: _____FAX: _____

Specific Information **Requested**:

_____

_____

_____

□ Dr. Benzick may **release** information to another health care provider or family member:

Name of Provider or Family Member: _____
Phone Number: _____FAX: _____

Specific Information **to be Released**:

_____

_____

_____

Dates Covered by this Authorization: From _____ to _____

This authorization provides that

- I may revoke this authorization at any time, provided that the revocation is in writing.
- Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and is no longer protected by this authorization or HIPAA privacy rules.
- This practice will not normally condition treatment, payment, enrollment in a health plan, or eligibility for benefits on my providing authorization for disclosure. However, in specific circumstances (e.g. substance abuse treatment, repeated suicidal thinking) Dr. Benzick may require the ability to communicate medical information to family if, as a licensed physician working in my best interest, he feels it is necessary.
- I have a right to access my protected health information to be used or disclosed.
- I will receive a copy of this completed and signed form upon request.

_____ _____
Signature of Patient or Representative named above Date