SSQ PSYCHIATRY LLC
HIPAA RELEASE OF INFORMATION AUTHORIZATION FORM

I, ____ hereby authorize SSQ Psychiatry LLC and its affiliates, its employees, and agents (collectively) to release to ____ **[Insert full name of person/organization]** my personal health information maintained by SSQ Psychiatry LLC, and its affiliates.

The following person or class of persons may receive disclosure of protected health information about me. **Records are to be mailed to:** ____

____

____

Specific description of information to be released (must include date(s) of service):

____

The information to be released will be used for the purpose described below:

____

I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

I understand that I have a right to revoke this authorization by providing written notice to SSQ Psychiatry LLC and its affiliates. However, this authorization may not be revoked if SSQ Psychiatry LLC and its affiliates, its employees, or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.

Name of Patient: ______________________________
Signature of Patient: ______________________________
Date: ______________________________

If applicable, Legal Representatives sign below:
By signing this form, I represent that I am the legal representative of the Patient identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

Name of Legal Representative: __________________________________

Signature of Legal Representative: __________________________________

Date: __________________________________