1164 Bishop Street, #1611, Honolulu, HI 96813
Phone: 808-261-7792 Fax: 808-792-0034

Authorization for Use and Disclosure of Protected Health Information

I authorize **Advanced Psychiatric Therapeutics, LLC** *to release/obtain the protected health information of*

*Patient Name: ______________________________ Birth date: _______________

Address: ______________________________ Phone #: _______________

To/From *Name or Institution: ______________________________

Address: ______________________________ City, State, Zip: _____________

*Information to be disclosed:		*Purposes for Use and/or Disclosure:
Date(s) of Service: ____________________		☐ At the request of the individual
☐ Discharge Summary	☐ ER report	☐ Legal Purposes
☐ History & Physical	☐ Laboratory Results	☐ Insurance
☐ Consults	☐ X-Ray/Imaging Reports	☐ Physician follow-up
☐ Progress Notes	☐ Entire Record	☐ Other:
☐ Other: Please specify: ____________________		

☐ The duration of this authorization is indefinite until revocation is requested in writing.

☐ This authorization expires on the following date or event: _________________.

I agree to the release of the following information even if it should contain in my medical record: Acquired Immune Deficiency Syndrome (AIDS) or HIV, Alcohol and/or drug abuse treatment, or behavioral or mental health services.

This authorization is voluntary. I understand that I can refuse to sign this authorization and Advanced Psychiatric Therapeutics, LLC (APT) will not condition my treatment, payment, enrollment or eligibility for benefits on the signing of this authorization except as allowed under federal privacy laws.

I understand that I may revoke this authorization at any time by notifying APT, in writing, of my revocation. I understand that the revocation will not apply to any information that already was released in reliance on this authorization.

I understand that the health information released under this authorization may be re-disclosed by the recipient and may no longer be protected under federal privacy regulations.

I hereby release Advanced Psychiatric Therapeutics, LLC from all liability and all claims of any nature whatsoever pertaining to the disclosure of information, or of any professional opinions, findings, or recommendations as contained in the records released to or by Advanced Psychiatric Therapeutics, LLC.

*Signature: ______________________________ *______________________
Patient or Personal Representative Print Name

*Relationship: ______________________________ *______________________
(Relationship to Patient) ·*Complete only if requestor is not patient* Date

*Items that MUST be completed for authorization to be valid.