Mona Venzon Rice, M.D., P.C.
Pediatric Psychiatrist

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Authorization for Release of Protected Health Information (PHI)

Patient Name: ____ Date of Birth: __________

I authorize Mona Venzon Rice, M.D., P.C. (Check all that apply.)

☐To release PHI to: ☐To obtain PHI from: ☐To exchange PHI with:

Name	E-mail	Phone # / Fax #	Information (Check all that apply)
☐Psychological therapist Or Counselor			☐complete record / all information ☐progress ☐treatment ☐history ☐evaluations ☐test results ☐discharge summary ☐other: ____________________
☐Primary care practitioner:			☐complete record / all information ☐progress ☐treatment ☐history ☐evaluations ☐test results ☐discharge summary ☐other: ____________________
☐Name of School & Staff (e.g. teacher, counselor)			☐medical conditions & treatment ☐doctor's recommendations for school ☐school behaviors ☐rating scales ☐educational evaluation/plan ☐other: ______________________
☐Other:			☐complete record / all information ☐progress ☐treatment ☐history ☐evaluations ☐test results ☐discharge summary ☐other: ____________________

For the purpose of (Check all that apply)

☐Assessment & treatment ☐Legal matter ☐Other: ___________________________________

☐Coordination & continuity of care ☐Personal use

-This authorization may be relied upon when transmitted by fax or e-mail. I further authorize the PHI to be sent by fax or e-mail. I agree to hold Mona Venzon Rice, MD harmless if any PHI transmitted by fax or e-mail does not reach the authorized recipient.

-I understand that this authorization will expire on the following date, event or condition: ____. I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose, or up to 2 years, whichever is earlier, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

-I understand that my information may not be protected from re-disclosure by the requester of the information; however, if this information is protected by the Federal Substance Abuse Confidentiality Regulations, the recipient may not re-disclose such information without my further written authorization unless otherwise provided for by state or federal law.

-I understand that if my record contains information relating to HIV infection, AIDS or AIDS-related conditions, alcohol abuse, drug abuse, psychological or psychiatric conditions, or genetic testing this disclosure will include that information. I also understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.

-I further understand that I may request a copy of this signed authorization.

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Signature of Patient (if 18 & above) or Signature of Parent or Legal guardian (if 17 & below or if adjudicated as ward) | Signer's Printed Name | Date Signed