Enhance Psych, Inc.

Raj Loungani, M.D.

DATE:_____

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize Enhance Psych, Inc. / Raj Loungani, M.D. to disclose or obtain the information described below.

Patient Information	Name_____ Date of Birth_____
Type of Authorization □ Self □ **Disclose** medical information **to**: □ **Obtain** medical information **from**:	**Primary Care Provider/General Physician and Specialist Physician(s):** Name_____ Contact Phone/Fax/Email_____ **Previous Psychiatrist (if applicable):** Name_____ Contact Phone/Fax/Email_____ **Therapist(s) (if applicable):** Name_____ Contact Phone/Fax/Email_____ **Other:** Name_____ Contact Phone/Fax/Email_____
Purpose for Request	□ **Collaboration of Care** □ Moving □ Insurance Claim □ Attorney □ Change of Insurance □ At Request of the Patient □ Other_____
Requested Information	□ **Entire Medical Record:** Patient histories, test results, referrals, consults, billing records, insurance records, and records sent to you by other health care providers □ **Portions of Medical Record** from _____ [Insert date] to _____ [Insert date]. □**Alcohol/Drug Treatment** □**HIV-Related Information** □Other: _____ _____

EXPIRATION DATE: This authorization will expire **three (3) years** from the date listed at the top of this form unless a different expiration date or expiration event is written here: _____.

REVOCATION: I understand that I have the right to revoke this authorization in writing any time, however I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the Practice shall not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this form. I understand that the revocation will not apply to my insurance company, Medicaid and Medicare when the law provides my insurer with the right to contest a claim under my policy. Written notice should be directed to Raj Loungani, Privacy Officer.

REDISCLOSURE: I understand that once the above information is disclosed, it may be redisclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

CONDITIONING: I understand that completing this authorization form is voluntary. I realize that treatment will not be denied if I refuse to sign this form.

Signature:_____ Date: _____ □ Patient □ Personal Representative