Darvin Hege, M.D., P.C.
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Patient Authorization for Use and Disclosure of Protected Health Information

Date: ______________

By signing this authorization, I authorize Darvin Hege, M.D., P.C. to receive/use and/or disclose the following protected health information (PHI) about me to:

____
(Name of entity to receive this Information)

____
(Address of entity to receive this Information)

Phone: ____________________ Fax: ____________________

For the purpose of ____
(ie. Continuity of care, at the request of the individual, disability, employment, etc)

This authorization permits Darvin Hege, M.D., P.C. to receive/use and/or disclose the following individually identifiable health information about me

( ) Any psychiatric information including notes, diagnosis, dates of service, etc.

( ) Summary report of psychiatric treatment

( ) Complete Medical/Psychiatric record (written/verbal documentation) including urinary drug screen results.

( ) Other (please specify) ____________________________________

I release you from all legal responsibilities or liabilities that may arise from this authorization. This authorization expires on __________(**unless there is a date written in the space provided, THIS RELEASE is valid for one year from the date printed below**). When my information is disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. I do not have to sign this authorization to obtain treatment.

If this form is a release for Dr. Hege to give information about me to a new therapist or doctor, I give that therapist or doctor permission to call me to arrange the first appointment.

No ☐ Yes ☐ Patient's Initials_______ Contact Number _________________

_______________________________________ ____________________
Signature of patient or legal guardian Date

____
(Patient Name- Please print)

Signature witnessed by:________________________________ Date:____________________

To revoke this authorization you must submit a request in writing to the address above.