

# Alabama Psychiatric Services, P.C.

2868 Acton Road  
Birmingham, Alabama 35243

## Authorization for the Request of Protected Health Information

This completed form authorizes Alabama Psychiatric Services, P.C. to **request** the following patient information:

Patients' Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS #: \_\_\_\_\_

I, the undersigned, authorize \_\_\_\_\_ at Alabama Psychiatric Services, P.C. to request the following **specific** patient information: (check those that apply)

- |  |  |
|--|--|
| <input type="checkbox"/> Progress notes. Inclusive dates: _____ to _____ | <input type="checkbox"/> IOP intake evaluation                   |
| <input type="checkbox"/> Copy of outpatient initial assessment           | <input type="checkbox"/> IOP treatment plan                      |
| <input type="checkbox"/> Outpatient treatment plan                       | <input type="checkbox"/> IOP summary of treatment to date        |
| <input type="checkbox"/> Summary of outpatient treatment to date         | <input type="checkbox"/> IOP discharge plan                      |
| <input type="checkbox"/> Summary of psychological evaluation             | <input type="checkbox"/> CD program initial assessment           |
| <input type="checkbox"/> Copy of inpatient H&P                           | <input type="checkbox"/> CD program treatment plan               |
| <input type="checkbox"/> Copy of inpatient discharge summary             | <input type="checkbox"/> CD program discharge summary            |
| <input type="checkbox"/> Copy of lab work related to _____               | <input type="checkbox"/> CD program summary of treatment to date |
| <input type="checkbox"/> Other: (describe) _____                         |  |

This information is to be requested from: (**specific name and address**)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

This information is to be used for the **specific** purpose(s) of:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**This authorization is valid for the period of one year from the date listed below. The patient signature listed below may revoke this authorization at any time and may refuse to sign the authorization. Upon signature, the patient will be provided a copy of this authorization. The information disclosed pursuant to this authorization will not be subject to re-disclosure by the recipient and will be covered by the federal Privacy Rules. The patients' eligibility for benefits, condition of treatment, payment or enrollment in any health plan will not be affected by this authorization. This authorization conforms to 45 CFR – Parts 160 and 164, Dec. 28, 2000.**

\_\_\_\_\_  
Patient Signature **Date:** \_\_\_\_\_

\_\_\_\_\_  
Parent / Patient Representative Signature **Printed Name and Relationship to Patient** **Date:** \_\_\_\_\_

\_\_\_\_\_  
Witness Signature **Date:** \_\_\_\_\_