Maegen S. Vincent, MD, LLC
Maegen S. Vincent, MD (she/her)
Adolescent, Young Adult, and Reproductive Psychiatrist
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Authorization to Obtain or Release Protected Health Information

Patient Name (Print): _____ Date of Birth: _____
Patient Address: _____

I authorize Maegen S. Vincent, MD, LLC
__TO RELEASE INFORMATION TO OR __TO OBTAIN INFORMATION FROM
(Place an "X" in the box that indicates if the information is being released OR requested.)
Name:_____
Address:_____
Phone #: _____ Fax #: _____

Purpose of this Authorization (check all that apply):

_____ Further Medical Care
_____ Personal
_____ Legal
_____ Research Related Treatment
_____ Creating health information for disclosure to third party
_____ Other: _____

I authorize release of the following Protected Health Information (check all that apply):

_____ Entire Record
_____ Medical History, Examination, Reports
_____ Progress Notes
_____ Admission Note/Discharge Summary
_____ Medication/Prescription Records
_____ Labs/Imaging Reports
_____ Financial
_____ Other: _____

In compliance with state and/or federal laws which require special permission to release otherwise privileged information, please release the following records:

_____ Alcohol/Drug Addiction Treatment
_____ HIV/AIDS
_____ Genetics
_____ Psychotherapy Notes
_____ Sexually Transmitted Infections (STIs)
_____ Other: _____

This authorization shall expire on _____ (date/event) and is needed for the period beginning _____ and ending _____.

I understand that if I do not specify an expiration date, this authorization will expire twelve months from the date on which it was signed. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken. I understand that I may inspect or request a copy of information that is used under this authorization. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment.

_____ _____
Patient's or Guardian/ representative's signature Date and time of signature

_____ _____
Print name of patient Print name of guardian/representative