Hamzavi Psychiatry and Wellness Center PLLC
Phone: 248-731-7458 Fax; 248-973-6068
www.hamzavipyschiatry.com

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name:_____ Date of Birth:_____

I authorize _____
(Name of Provider/Therapist)

_____
(Street Address and City)

_____
(Phone and Fax)

to disclose information in my patient record as set forth below:

1. Disclosure may be made to Hamzavi Psychiatry & Wellness Center, PLLC.
2. Specific description of the information to be used or disclosed is for Collaboration of Care and may also include
   _____.
3. This release of information is ☐ or is not ☐ a reciprocal release of information.
4. I understand the information used or disclosed may be subject to re-disclosure by the person(s) receiving it and no longer protected by the federal policy regulations.
5. I understand I may revoke this authorization by notifying Hamzavi Psychiatry & Wellness Center, PLLC in writing of my desire to revoke it. However, I understand that if I revoke this authorization, it will not have any effect on actions taken by the above named in reliance on this authorization.
6. I understand Hamzavi Psychiatry & Wellness Center, PLLC may not condition my treatment on whether or not I sign this authorization.

Patient Signature:_____ Date: _____

Witness Signature:_____ Date: _____