



# Chesapeake Neuro-Behavioral Health

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## PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize Chesapeake Neurobehavioral Health to (**circle one**) RELEASE or REQUEST certain Protected Health Information (PHI) about me from:

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*Name of entity to receive this information*

This authorization permits Chesapeake Neurobehavioral Health to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of service, type of service(s), level of detail to be released, origin of information, etc.)

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The information will be used or disclosed for the following purpose and to/from the following individual(s):

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If requested by the patient, purpose may be listed as "at the request of the individual". The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on:

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The practice \_\_\_\_\_ **will** \_\_\_\_\_ **will not** receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization to receive treatment from Chesapeake Neurobehavioral Health. In fact, I have the right to refuse to sign this authorization. When my information is used or 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. My written revocation must be submitted to the Privacy Office at: Chesapeake Neurobehavioral Health, 8191 Jennifer Lane, Suite 200, Owings, MD 20736.

**Signed by:**

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Patient's Name (print)

\_\_\_\_\_  
Today's Date

\_\_\_\_\_  
Print Name of Patient or Legal Guardian

\_\_\_\_\_  
DOB

\_\_\_\_\_  
SS Number

*Patient/guardian to be provided with a signed copy of authorization.*