Michelle Weil, M.D.
PSYCHIATRIST

OPTIONAL RELEASE OF MENTAL HEALTH INFORMATION

(If you do not agree to this release, please leave this page blank and do not sign below)

Patient Name: _____ Date of Birth: _____

I authorize that information may be exchanged between the following third-party(ies) and Michelle Weil, M.D. and Michelle Weil, M.D. PLLC ("MWMD"):

Name: _____

Relationship to Patient: _____

Address: _____

Phone: _____ Fax: _____

Name: _____

Relationship to Patient: _____

Address: _____

Phone: _____ Fax: _____

I authorize the disclosure of the following information:
_____ All Information _____ Diagnosis _____ Clinical Progress Notes
_____ Psychological Evaluation _____ Medication Information
_____ Discharge Summary

This information and these records may contain information concerning HIV testing or AIDS diagnosis or treatment.
☐ - I consent ☐ - I do not consent to have information on HIV testing or AIDS released.

This information and these records may contain information concerning substance abuse diagnosis or treatment.
☐ - I consent ☐ - I do not consent to have information on substance abuse diagnosis or treatment released.

I understand that depending on my election above, information disclosed pursuant to this authorization may include information relating to sexually transmitted disease, HIV/AIDS, treatment for alcohol and drug abuse, and psychological or psychiatric conditions, unless later restricted as detailed below. Once information is disclosed pursuant to this signed authorization, I understand that general federal privacy laws designed to protect confidential or private information, including HIPAA, may not apply to the recipient of the information, and therefore, those regulations may not prohibit the recipient from re-disclosing the information.

I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. In order to revoke this authorization with respect to information other than drug and alcohol treatment program records, I understand that I must provide written notice by reasonable means to Dr. Weil and MWMD. If not revoked earlier, this release and authorization will expire one year from the most recent date signed. I release Dr. Weil and MWMD and all of the above parties from any and all liability that could result from disclosing information subject to this release. I further acknowledge a copy of this release and authorization may be utilized with the same effectiveness as the original.

I understand that I may refuse to sign this authorization, and this will not affect my ability to receive treatment with Dr. Weil and MWMD. Dr. Weil does not recommend email as a means of communication. There are some risks that any protected health information that may be contained in such email may be disclosed to, or intercepted by, unauthorized third parties. By signing this form, I acknowledge that email is not secure and I am releasing Dr. Weil and MWMD from any liability relating to unauthorized disclosure of information contained in email correspondence.

_____ _____

Signature of patient or authorized representative Date

_____ (print name)

_____ (print patient name & authority to act, if applicable)