AUTHORIZATION TO USE AND DISCLOSE
PSYCHOLOGICAL/PSYCHIATRIC INFORMATION

To Healthcare Provider:

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Name of Patient/Individual:_____ Date of Birth:_____

I, the undersigned, authorize you to disclose to GAL/AMC, my health information, including but not limited to: case history, hospital records, office visit records, telephone logs, physician/hospital correspondence, psychiatric history, consent forms, prescription/medication history, correspondence to/from patient, physicians, other healthcare providers and/or insurance companies, any and all psychotherapy notes, and any other medical or hospital records which may be requested to GAL/AMC.

Expiration

This Authorization will expire the later of one year from the date of execution or upon final disposition of litigation.

I understand that **GAL/AMC** is not a healthcare provider or health care plan covered by the Federal Privacy Rule and, therefore, that the information used or disclosed as described above may be re-disclosed by the recipient and no longer be protected by the Privacy Rule. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/AIDS-related information and psychiatric/mental health information.

I understand that I may revoke this Authorization in writing at any time, except to the extent that the above healthcare provider has already taken action in reliance on this Authorization.

I understand that my refusal to sign this Authorization will not jeopardize my right to obtain present or future medical treatment except where disclosure of the information is necessary for the treatment.

I understand that my refusal to sign this Authorization will not jeopardize my right to obtain present or future treatment for psychiatric disabilities except where disclosure of the

information is necessary for the treatment.

I understand that I am not required to sign this Authorization as a condition of treatment, payment, enrollment, or eligibility for benefits.

By signing below, I acknowledge that I have read and understand this Authorization form.

_____ _____
Signature of Patient or Patient's Authorized Representative — Date

If signed by Patient's Representative, please print name and describe relationship to Patient or other authority to act:

_____ _____
Name — Relationship to Patient