Nurture Psychiatry & Psychotherapy
Sheela Masifi, MD

Authorization to Release Health Information

* I authorize the sending and receiving of information between Dr. Masifi and the following providers/individuals:

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* For which of the following do you authorize the transfer of information?
  - ☐ Mental health records
  - ☐ Communicable diseases (including HIV/AIDS)
  - ☐ Alcohol/drug abuse treatment
  - ☐ Other (describe)

This information may be used by the recipient for treatment, consultation, billing, claims, payment, or other purposes as I may direct.

I understand that I have the right to revoke this authorization, in writing, at any time.

I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

* For how long should this authorization be in effect?
  - ☐ Indefinitely
  - ☐ Until treatment is completed
  - ☐ Other (describe)

* Signature (required)

_____

Full name (printed)

_____

Date of Birth

_____

Today's Date

_____