



PRINTED NAME: _____

Date: _____ DOB: _____

I authorize Vatsal Thakkar, M.D., whose office is located at the address below, to disclose and/or obtain information from the following physician, psychiatrist, hospital, other treatment provider or organization, relative, friend, or any other person I choose to name below:

NAME: _____

ADDRESS: _____

CITY, ST: _____ ZIP: _____

PHONE: _____ FAX: _____

By signing below I acknowledge that the following information may be released, discussed, or disclosed. If you agree to the release of all protected health information (PHI), then check the first option. If you want to limit what is released, then choose the option you agree to and check that option.

- Complete Medical/Psychiatric Record (FULL)
- or
- Discharge Summary and/or Progress Notes
- Diagnosis and Medication Records
- Substance Abuse Information (including assessment & treatment records)
- Treatment Plan
- Results of labs/tests: _____
- Correspondence regarding: _____
- Other (please specify): _____
- For incoming or outgoing referrals

I understand that my records are protected under federal regulations governing Confidentiality of Protected Health Information (PHI) under HIPAA and Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2 and cannot be disclosed without my consent unless otherwise provided for in the regulations. I also understand that I may revoke this authorization and must do so in writing and present this written revocation to the office of Solstice Psychiatric Consulting, P.C. Unless otherwise revoked, this consent expires in 12 months from this date. I understand that once information is disclosed per my authorization, the information may be redisclosed by the recipient in accordance with applicable laws and regulations and it may not be protected by federal or state privacy regulations.

SIGNATURE: _____ DATE: _____