United Health Professionals, Inc.
Authorization for Release of **BEHAVIORAL HEALTH** Information

143 Peyton Street
Barboursville, WV 25504

Patient Name Last First MI Maiden/Other

DOB Mo Day Year SS# Med Rec #

Address City State/Zip

Day Phone (with area code) Evening Phone Cell Phone

CHOOSE ONE

[ ] I authorize UHP to release information ***TO:***

name of provider or facility

address

city, state, zip

phone or fax number with area code

[ ] I authorize UHP to obtain information ***FROM:***

name of provider or facility

address

city, state, zip

phone or fax number with area code

RECORDS

I specifically authorize the release of **BEHAVIORAL HEALTH RECORDS** to/from **Dr. Debra Stultz and her associates** at United Health Professionals, Inc. Psychiatrist notes only

Please specifically approve **each** area of records you give us the permission to release or receive:

( ) Psychiatric Evaluations ( ) Sleep Study Evaluations ( ) Progress Notes ( ) Psychiatrist notes only
( ) Psychotherapy Notes ( ) Discharge Summaries ( ) Phone Call Documentation ( ) Lab Results
( ) HIV and Drug Screen Results ( ) Medication Information ( ) Referral Letters ( ) History and Physicals
( ) Other: _____

PLEASE INCLUDE THE ABOVE RECORDS FROM THE TREATMENT DATES LISTED BELOW:

Treatment dates from _____ to_____ **DATES must be filled in! Example: 2005-2007; "All" is not permitted**

PURPOSE

Information is to be released for the following purpose(s):

( ) Case Referral ( ) Hospital Admission ( ) Discharge Planning ( ) Updates of Progress
( ) Changing Physicians ( ) Consultation/Second Opinion ( ) Insurance ( ) Legal
( ) School ( ) Worker's Compensation ( ) Other (must specify): _____

NOTE

I understand the following:

- **I understand records I am releasing include psychiatric and substance abuse information.**
- This authorization will expire 60 days after I have signed this form.
- I may revoke this authorization at any time by notifying the providing organization in writing. My notification will be effective on the day it is received expect to the extent action has already been taken on the original request.
- The information used before this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.

SIGN HERE

Signature of Patient/Legal Guardian/Authorized Person Date Witness

Records Received by Date Relationship to patient

***Office Use*:** Date Completed: by: ID presented: Fee collected: $