Anna R. Flynn, M.D.

Child, Adolescent & Adult Psychiatry

AUTHORIZATION FOR USE AND DISCLOSURE OF INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or a health care provider, that organization may also disclose my health information. If this happens, I understand that my information may no longer be protected by federal privacy regulations.

Patient name:_____

Persons/Organizations authorized to release and receive the information: _____

_____

_____

_____

_____

Specific description of information (including date(s)):_____

_____

The patient and/or the patient's representative must read and initial the following statements:

1. I understand that this authorization will expire _____ Initials:_____

2. I understand that I may revoke this authorization at any time by notifying Dr. Flynn in writing. But, if I do revoke this authorization, my revocation will not have an effect on any actions Dr. Flynn took in reliance upon my authorization before it received my revocation. Initials:_____

   You may revoke this authorization by signing a Revocation of Authorization form and returning it to Dr. Flynn. To request a Revocation of Authorization form, you may contact Dr. Flynn at the address above.

3. I understand that Dr. Flynn will not condition my treatment, or payment for health care services, upon my completing and signing this authorization.

   Initials:_____

Patient Name: *(Please Print)* _____

Printed name of patient's guardian (Patients 17 and younger)**:**_____

Relationship to patient:_____

_____ _____

Signature of patient (Patients 12 years and older) **Signature of patient's guardian** (Patients 17 and younger)

Date _____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.

Anna R. Flynn, M.D.
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