Main Street Psychiatry & Psychotherapy

Laura Rosenbaum-Bloom, MD

4101 Main Street, Suite C

Hilton Head Island, SC 29926

Office-843-342-6000 Fax: 843-342-6001

Authorization to Release and Disclose Personal Health Information

Patient:_____ _____

Last name First name middle int.

Street Address_____

Street City Zip code

SSN#_____Date of Birth_____

Information released to:

Health Care Dr/facility_____

Street_____

City_____Zip Code_____

Phone_____/Fax_____

Information released from:

Laura Rosenbaum-Bloom, MD

4101 Main St, Suite C

Hilton Head Island, SC 29926

Office: 843-342-6000

This information shall include the following: (check all that apply)

Date of Service to release_____

__Consultation Reports __Medication Reports __Most Recent Labs __Neuropsych Testing

__Most Recent Chart Notes __Progress/Office notes __Psychological Testing __Mental Health Treatment____

__Substance Abuse__ __HIV Testing Results__ __Discussion Both Ways____ Other_____

Reason for Disclosure:

__Continue Treatment __Insurance __Worker's Compensation __Disability __Legal __Personal

Restrictions:

I understand that I have the right to cancel/revoke this authorization at any time. I understand that if I cancel/revoke this authorization, I must do so in writing. I understand that the cancellation/revocation will not apply to information which has already been released in response to this authorization. Unless revoked, this authorization is valid 90 days from the signature date below, or for the following time period: _____.

By signing this form, I authorize the above healthcare provider/entities to release confidential health information about me, by releasing a copy of my medical records, or a summary or narrative of my protected health information. I have read this authorization and I understand all the information.

Signature of Patient or Legal personal representative_____**Date**_____