julia BURROW, MD & ASSOCIATES

RELEASE OF INFORMATION

The purpose of this disclosure is for Coordination of Care

Patient Name: _____ Date of Birth: _____

Authorization will expire in ( )six months ( )one year ( )on file

Name of Person(s) or Provider/Facility to disclose information to-_____

Relationship tot Patient: _____ Address: _____

Phone:_____ Fax:_____

Description of specific information to be disclosed (Check all that apply):

( )All relevant psychiatric information ( )Notes ( )Diagnoses ( )Billing information ( )ALL

Revocation and Conditions: I understand that I have the right to revoke this authorization at any time by notifying the provider in writing with written name and date of birth of said patient. I understand that revocation of this release will not apply to information that has already been released and does not apply to my insurance company when law provides my insurer with the right contest a claim under my policy. I understand that the information disclosed is protected by law and may not be re-disclosed without my written permission or authorized by law. Above provider reserves the right to release information permitted by authorizer in any manner the we deem to be appropriate and consistent with applicable law, including but not limited to, verbal, paper, or electronic format, I understand there is a potential that the private information may no longer be protected by HIPPA once release from provider to receiver and Julia D. Burrow, MD and Associates are not legally responsible for any of the information once it leaves the facility.

Printed name of patient or authorized representative: _____

Signature of patient or authorized representative: _____

Date of Signature: _____ Signature of Witness: _____