John Naus, M.D., P.A. – General Psychiatry -
5017 Heritage Avenue, Suite #102, Colleyville, Texas 76034
Phone: (817) 545-9100 Fax: (817) 545-9134

Authorization for the Use or Disclosure of Protected Health Information:

Patient Name:_____ Date of Birth:_____
Social Security Number_____

I,_____ DO HEREBY FREELY AND VOLUNTARILY AUTHORIZE THE OFFICE OF JOHN NAUS M.D., P.A. TO OBTAIN OR DISCLOSE RECORDS OF MY HEALTH INFORMATION TO OR FROM:

Individual, Facility,Organization:_____

Telephone Number:_____ Fax number:_____

Address:_____

Suite:_____ City/State/ Zip:_____/_____/_____

THE PURPOSE OF THIS AUTHORIZATION IS TO: 1. Facilitate the execution of healthcare, 2. Allow the coordination of treatment, 3. Allow for discussion and planning to take place, between my care providers, concerning my health information. 4._____

Information to be Obtained/Released includes:

X	All prior and current Medical Records	X	Progress Notes
X	Psychotherapy Records	X	Admission Psychiatric Evaluation
X	Psychological Testing	X	Hospital records
X	Verbal Exchange of Information	X	Treatment Plans
X	Discharge Summary	X	History and Physical
X	Outpatient/Inpatient: Laboratory Tests, EEG, EKG	X	Drug/Alcohol Screening Results

Optional: I **Do NOT** wish to have the following information released:

My medical and psychotherapy records may include information regarding testing, diagnosis and treatment of mental health, drug, alcohol, acquired immune deficiency syndrome (AIDS), hepatitis B, venereal disease, tuberculosis, and other communicable diseases. I understand that such information is confidential and is protected by federal law. I understand that the provision of health care treatment to me cannot be conditioned upon my agreement to sign an authorization for the disclosure or use of my health information for purposes other than for treatment, payment and health care operations. I understand that the potential exists for the health information that is released with my authorization to be re-disclosed by the recipient, and to be no longer protected by the federal HIPAA Law.

I understand that I have the right to revoke this authorization at any time by giving written notice to John Naus M.D., except to the extent that Dr. Naus has already taken action in reliance on it. This authorization will expire in five years from the date signed or as of _____, whichever comes first.

Patient signature:_____Date:_____

Guardian signature:_____Date:_____