Authorization For Release Of Confidential Information

I, _____ of _____
(Patient's Name) (Date of Birth) (Address)

_____
(City, State) (Zip Code) (Phone Number)

Authorize Konzer Psychiatric, PC/Dr. Tia Konzer, DO, 903 Northeast Dr., Ste. 102, Davidson, NC 28036, Phone 704-997-5154, Fax 704-997-5174, To release my medical information to and/or obtain my medical information from:

Organization and/or Person: _____ Relationship to Patient:_____

Address: _____

Phone: _____ Fax: _____ Email: _____

I hereby authorize **Konzer Psychiatric, PC** to release/obtain copies of **Psychiatric Evaluation, Psychiatric Summary, Progress Notes, Psychotherapy Notes, Drug and Alcohol, HIV and Medical Information except for restrictions listed here**: _____ from the health care record pertaining to my hospitalization/treatment of _____(specify dates of treatment)

This information is being disclosed for the following purpose (s): Check at least one

( ) Changing physicians	( ) Legal Purposes	( ) Insurance
( ) Continuation of Care	( ) Social Security/Disability	( ) School
( ) At my (Patient) request	( ) Workers Compensation	( ) Second Opinion

This authorization is valid until one year. I understand that if I fail to specify an expiration date or condition, this authorization is valid for the period of time needed to fulfill its purpose for up to one year, except for disclosures for financial transactions, wherein the authorization is valid indefinitely. I also understand that I may revoke this authorization at any time in writing. I further understand that any action taken on this authorization prior to the rescinded date is legal and binding.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment, payment for services, or my eligibility for benefits; however, if a service is requested by a non-treatment provider (e.g., insurance company) for the sole purpose of creating health information (e.g., physical exam), service may be denied if authorization is not given. If treatment is research-related, treatment may be denied if authorization is not given.

I further understand that I may request a copy of this signed authorization.

_____ _____
Patient/Patient Representative Signature Date

Should you choose to REFUSE/REVOKE PERMISSION to release the above listed information, sign below.

_____ _____
Patient/Patient Representative Signature Date

Legal Authority to sign for patient: __ Guardian __ Administrator/Executor __Parent
__ Attorney in Fact __ Next of Kin __ Other (specify) _____
Patient is: __Minor __Disabled __Deceased __Incompetent __Incapacitated

Konzer PSYCHIATRIC

Konzer Psychiatric, PC
Tia Konzer, DO
903 Northeast Dr.
Suite 102
Davidson, NC 28036

PHONE: 704-997-5154
FAX: 704-997-5174
EMAIL: drkonzer@outlook.com
WEBSITE: www.drkonzer.com