**AUTHORIZATION FOR THE RELEASE OF INFORMATION**

**Leslie A. Deckter, M.D., 3001 Highland Ave, Cincinnati OH 45219-2315, Phone 513-961-8830, Fax 513-487-3770**

Patient Information (Please Print):

Name: Date of Birth: Social Security #:

Street Address, City, State, Zip Code:

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PROTECTED HEALTH INFORMATION (PHI) TO BE OBTAINED OR DISCLOSED

Inpatient Dates of Service:_____ and/or Outpatient Dates of Service:_____

[ ] Outpatient Assessment [ ] Patient Follow-up Report [ ] Discharge Summary [ ] Lab reports [ ] Inpatient Assessment

[ ] Physician Orders { ] MRI reports [ ] Social Work Assessment [ ] Medical History and Physical [ ] Consultation reports

[ ] ECT record [ ] Progress Notes [ ] Psychological Testing [ ] Treatment Plan [ ] TMS record [ ] Nursing Assessment

[ ] other_____

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[ ] Disclosed records to: [ ] Obtain Information from:

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Individual /Agency/Hospital

Address, City, State, Zip Code

Telephone #: Fax # Reason for Disclosure

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I, the undersigned authorize the above named parties to use and /or disclose information from my medical or financial record as specified above.

I understand and acknowledge that this authorization extends to all or any part of the records designated above, which may include documentation of treatment for mental health disorders, alcohol/drug abuse or dependences, and /or HIV/AIDs test results or diagnosis. I expressly consent to the release of information as designated above. Furthermore, I consent to the release of the facsimile transmission of my protected health information as necessary.

This authorization will expire in six (6) months unless otherwise specified. I understand that I or my legal guardian may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance of the authorization. I also understand that Aimee J. Rusk, M.D. may charge a reasonable fee for the preparation, copying and postage as allowed by state law for copies of medical records.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits, unless the treatment is for research purposes or unless the provision of treatment is related solely to the disclosure of my PHI to a third party as when requested by my employer.

I understand that if the person/entity that receives the above PHI is not a health care provider/health plan covered by federal privacy regulations, the PHI described above may be re-disclosed by such person/entity and will likely no longer be protected by the federal privacy regulations.

Patient Signature (if over 18)_____Date_____

Signature of [ ] Parent [ ] Legal Guardian _____ Date_____

Witness_____Date_____