NOVA NEUROPSYCHIATRY, PLLC
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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: ____

Date Of Birth: ______________________________

I hereby authorize Dr. Alexandru Serghi, M.D. (please check one or more of the options below)

_____ to exchange information relevant to my psychiatric care with:

_____ to release information relevant to my psychiatric care to:

_____ to receive information relevant to my psychiatric care from:

____

Name of Individual, Institution, or Organization

____

Address/Contact Information

The purpose of the use of this authorization is:

_____Continuity of Care _____Insurance _____Legal _____Personal Use

Approximate Dates of Treatment: ____

This authorization for release of protected health information will remain valid until (please check only one of the options below):

_____One year from this date _____Termination of Treatment _____Revoked

I understand that this authorization for release of protected health information is voluntary and that I may refuse to sign this authorization. I further understand that I may revoke this authorization at any time by notifying Dr. Alexandru Serghi, M.D., in writing.

____ _________________________

Patient’s Signature Date