Sonia Juneja, M.D.

Washington Family Psychiatry LLC
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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

All items on this authorization must be completed or the request will not be honored. Use "N/A" if not applicable.
Patient Name ____
Address ____
____
Date of Birth ______________________

For this authorization, "My Health Information" means (check all that apply) and may include information regarding substance abuse treatment:

Hospital Records

____Emergency Room Record ____Psychiatric Admission Note
____Admission Physical ____Psychiatric Evaluation/Diagnosis
____ Psychosocial Assessment ____Progress Notes
____Drug & Alcohol Treatment Record ____Discharge summary
____Diagnostic Tests/Results (Lab, X-rays, and other Test Results)
____All of the above ____ Other ________________________

Outpatient Records

____ Initial Diagnostic Evaluation ____ Progress notes
____Medication Records ____Treatment Plans
____Psychological Testing ____Summary of Treatment
____ Medical Records ____ All of the above

For the date(s) of service starting/ending____
I authorize Sonia Juneja, M.D. to ________Release My Health Information
________Receive My Health Information
From/To Name ____
Address ____
____
For the following purpose:
_____Coordination of medical care
_____ Providing information to workplace or insurance for disability, leave of absence, or to assist in payment
_____ Obtaining or providing collateral information to facilitate care
_____ Providing clinical information to state or regulatory agencies
_____ Other____

I understand that I have the right to receive a copy of this authorization. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Sonia Juneja, M.D.. I understand that a revocation is not effective to the extent that the Practice has relied on this authorization in its actions. I certify that I have read, signed and received a copy of this authorization upon my request. I understand I may be billed for copies of my medical record according to HIPAA State of Maryland and Federal Law.

Patient's Signature__________________________________ Date________________