AUTHORIZATION TO OBTAIN, RELEASE, OR REVIEW PROTECTED HEALTH INFORMATION

Burgundy Prime, Inc.
1337 S. International Pkwy, Suite 1301
Lake Mary, FL 32746

www.burgundyprime.biz
Phone: (407)878-0022
Fax: (888)815-1039

Patient Name: _____ **Address:** _____

Date of Birth: _____ _____

Phone #: _____

Burgundy Prime, Inc.
1337 S. International Pkwy, Suite 1301
Lake Mary, FL 32746

Phone: (407) 878-0022
Fax: (888)815-1039
Relationship to Patient: Psychiatrist

I AM REQUESTING THAT BURGUNDY PRIME, INC BE AUTHORIZED TO ☐ OBTAIN ☐ RELEASE MY PROTECTED HEALTH INFORMATION WITH THE PERSON/FACILITY LISTED BELOW. (PLEASE CHECK ONE OR BOTH BOXES.)

PERSON/FACILITY AUTHORIZED TO RELEASE/OBTAIN THE PROTECTED HEALTH INFORMATION

Name: _____

Address: _____

Phone: _____

Fax: _____

RECORDS REQUESTED AND METHOD OF DELIVERY

Format of Records:	✓Paper	✓Electronic	✓Voice/Phone
Method of Deliver:	✓Pick up	✓Fax	
Purpose of Disclosure:	✓Continued treatment	Other: _____	
Dates Requested	All	Only: _____ --- _____	
Records Requested:	All	Only: _____	

The authorization will expire on the following date, event or condition:

I understand that this authorization extends to all or any part of the records designated above, which may include psychiatric information, and/or genetic counseling/testing, and/or alcohol/drug abuse, and/or AIDS (Acquired Immunodeficiency Syndrome), and/or may include the result of an HIV test or the fact that an HIV test was performed. I expressly consent to the release of information as designated above unless initialed above or otherwise required by law.

If I fail to specify an expiration event or condition, the authorization will expire in one year. I understand that this authorization is revocable upon written notice to the office where the original authorization is retained, except to the extent that action has already been taken on this authorization. I understand that my protected health information that is used or disclosed under this authorization may be subject to re-disclosure by the recipient and the privacy of my protected health information may no longer be protected by law. I further understand that Burgundy Prime Inc may not condition the provision of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of this authorization. I understand that I can receive a signed copy of this form upon request.

Patient Signature: _____ **Today's Date:** _____