AUTHORIZATION FOR USE/DISCLOSURE
OF HEALTH INFORMATION

Authorization for Use/Disclosure of Information:

I voluntarily consent to authorize my health care provider, Peter Gager, Ph.D. to use or disclose my health information to FAA Aerospace Medical Certification Division and the provider/AME below:

Patient Name and Date of Birth: ______________________________

Address: ____

Telephone: ____

Recipient **Provider/AME** Name: ______________________________

Address: ____

Telephone: ____

Purpose: I authorize the release of my health information for the following specific purpose: Prior authorization for treatment from my health insurance carrier and treatment planning.

Information to be disclosed: I authorize the release of the following health information: (check the applicable box below)

- ❑ The following records or types of health information: History of assessment, diagnoses, and treatment of psychiatric and related conditions (including therapy and medications).

Term: I understand that this Authorization will remain in effect:

- ❑ From the date of this Authorization until the _____ day of ________, 20___.
- ❑ Until the Provider fulfills this request.
- ❑ Until the following event occurs: ______________________________________

Redisclosure: I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to sign/right to revoke: I understand that signing this form is voluntary and that if I don't sign, it will not affect the commencement, continuation or quality of my treatment at TMS Center. If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation to TMS Treatment Center at the address listed above. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

Questions: I may contact the KY Cabinet for Health and Family Services for answers to my questions about the privacy of my health information by telephone at (800) 635-2570.

___________________________________ ________

Patient Signature Date