Jonathan G. Still, M.D. LLC

Board Certified in Psychiatry, American Board of Psychiatry and Neurology
Fellow, American Psychiatric Association
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AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL INFORMATION

Patient Name: _____ Date of Birth: _____ Social Security #: _____

I, _____ authorize the information specified below to be disclosed as follows:

From / To (please circle)	Jonathan G. Still, M.D. LLC 74 N. Pecos Rd, Suite C Henderson, NV 89074	From / To (please circle)	Name of Person: _____ Name of Organization: _____ Address: _____ City: _____ State: _____ Zip: _____ Phone: _____ Fax: _____

Disclosure shall be limited to the following specific information contained in my records and/or obtained during the course of my assessment and services by Jonathan G. Still, M.D. LLC (check each item):

	Yes	No		Yes	No
Assessment and Diagnostic Summaries	____	____	Progress Notes	____	____
Records of Correspondence	____	____	Specify Dates: _____		
Treatment Plan	____	____	Attendance Record	____	____
Laboratory and/or Imaging Results	____	____	Billing Payment Records	____	____

I am requesting that this information be disclosed for the purpose(s) of: _____

_____

I am aware of the confidential and/or privileged nature of the information being disclosed, and understand the benefits and/or disadvantages of disclosing such information. I hereby release Jonathan G. Still, M.D. LLC and its affiliates, representatives, and assigns for all legal liabilities that may result from the release of this information.

This authorization shall be in full force and effect until (please check):

_____ End of treatment

_____ 365 days after the date on which I signed below

I acknowledge that I have the right to revoke this authorization at any time, by sending written notification to Jonathan G. Still, M.D. LLC. I understand that a revocation is not effective if Jonathan G. Still, M.D. LLC has already taken actions in reliance on the authorization.

I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state privacy laws and regulations.

I understand Jonathan G. Still, M.D. LLC will not condition my treatment, payment, or enrollment or eligibility for services on whether I provide this authorization.

_____	_____
Patient/Legal Guardian Signature	Date
_____	_____
Patient/Legal Guardian Name (please print)	For Legal Guardian: indicate authority to sign
_____	_____
Staff Witness Signature	Date