ADROITA
Care. Simply Different.

ADROITA
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PATIENT INFORMATION	
Name: _____	Phone: _____
Address: _____	Date of Birth: _____
_____	Email: _____

AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

I, or my Personal Representative, authorize the use and/or disclosure of my protected health information (PHI) as described on this form. I understand that once my information is disclosed to the recipient, neither Adroita nor any of the Adroita providers can guarantee that the recipient will not disclose the information to a third party or as required by law. I also understand that signing this authorization is voluntary and that my treatment, payment, enrollment, or eligibility of benefits will not be conditioned by my authorization of this use or disclosure. I understand that I have the right to revoke this authorization at any time, except to the extent that action has already been taken in reliance on this authorization. If I wish to revoke this authorization, I understand that I must do so in writing and present it to Adroita's Privacy Officer.

I authorize **Pandian Medical Corporation (dba) ADROITA to:**

☐ Obtain or Use PHI from _____

☐ Disclose PHI to _____

PURPOSE The purpose of the authorized obtain or disclosure is:

- ☐ To improve my providers health care operations.
- ☐ Treatment Coordination of care between my providers.
- ☐ **Other (specify): _____**

WHAT MAY BE DISCLOSED: I authorize Adroita, including and the above mentioned provider(s), to use or disclose the following information:

- ☐ Other (specify):_____
- ☐ Complete mental health medical record.

By checking any of the boxes next to a category of confidential information listed below, I specifically authorize the use or disclosure of that category of information, if any such information will be used or disclosed pursuant to this Authorization:

- ☐ **Information about a mental health**
- ☐ Information about Substance Abuse
- ☐ **Psychotherapy Notes ONLY (this must be the only box checked, authorization for psychotherapy notes cannot be combined)**

EXPIRATION DATE OR EVENT: This authorization will remain in effect one (1) year after this authorization is signed.
I have read and understood this Authorization and have had a chance to ask questions about the use and disclosure of my information.

_____ _____
Patient or Personal Representative Signature **Date**

_____ _____
Name of Personal Representative (if applicable) **Authority of Personal Representative**

_____ _____
Witness Signature **Date**

FOR OFFICE USE ONLY	Witness Name (Please print):	