faxed 12-5-11

609-597-5327
609-488-3699 fax

OCEAN MENTAL HEALTH SERVICES, INC.

AUTHORIZATION TO OBTAIN / DISCLOSE HEALTH INFORMATION

THIS FORM MUST BE COMPLETED IN FULL

CONSUMER NAME: Robert Williams DATE OF BIRTH: 9/17/1990

ADDRESS: 215 W22Nd St, Ship Bottom TELEPHONE NUMBER: 609 891 6513

I hereby authorize Ocean Mental Health Services, Inc. to ☐ obtain ☑ disclose the information below:
(circle one or both)

Dr Yassin Beacon Ave, Manahawkin, NJ
609-597-7799 Fax 609 242-1906

The information to be used by the above is for the following purpose:

CONTINUING CARE X ATTORNEY / LEGAL ___ INSURANCE ___ OTHER: ___

Information may be faxed to the receiver: Yes ___ No ___

Information to be shared:

- ☐ Psychiatric History
- ☐ Psychological Testing
- ☐ Treatment Plan
- ☐ Discharge Summary
- ☐ Progress Notes
- ☑ Medications
- ☐ Billing Information
- ☐ Drug & Alcohol Abuse Information
- ☒ Other (please specify) labs, dx
- ☐ HIV / AIDS
- ☐ Infectious Disease

Please send Tegretol level

Please forward information directly to: Pat Comerford / file

It is my intent that the use of the information furnished is prohibited for any purpose other than stated above and that the recipient is prohibited from disclosing this information to any other party to whom disclosure is not necessary or required for the purpose stated above.

I understand that I have the right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the Privacy Officer. I understand the revocation will not apply to the extent that Ocean Mental Health Services, Inc. has already taken action in reliance on this authorization. This authorization will automatically expire at discharge, unless I otherwise specify that this authorization will terminate on the following date or concurrently with the following event or condition:

I understand that authorizing the sharing of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment, payment or enrollment or eligibility in benefits. I understand I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand any disclosure of information carries with it the potential for an un-authorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my personal information, I can contact the Privacy Officer at 732-349-5550.

DATE: 2/5/11 CONSUMER SIGNATURE: [signature]

WITNESS: [signature] LEGAL REPRESENTATIVE: ___

WITNESS: ___ CIRCLE ONE: PARENT / LEGAL GUARDIAN / HEALTH CARE PROXY

(Two witnesses required for verbal consent) *ATTACH THE DOCUMENT OF AUTHORITY*