# Vortex Psychiatry

4155 Blackhawk Plaza circle, suite 240, Danville, CA 94506

Phone: (925) 648-2650 Fax: (925) 648-2530

## Consent To Exchange Medical Information

Patient's Name:_____ DOB:_____ Age:

I authorize the exchange of:

- Clinical Information
- Medical Information
- Financial Information
- Appointment Information
- Other Information

And/or documentation between Vortex Psychiatry and _____.

I understand that my protected health information may be used for treatment, payment, or health care operations. I understand I have the right to review the privacy practice, if applicable. I understand that I have the right to request a restriction on the use of protected health information, but that the Professional Staff is not required to honor the request. If the professional staff agrees to the request, the request is binding on that professional staff member. This consent does not expire unless the above–named patient notifies Vortex Psychiatry, in writing, that this consent is invalid. I understand that I have a right to revoke this consent in writing except to the extent that action has been taken in reliance on this consent. I understand that information used or disclosed pursuant to this consent may be subject to re-disclosure by the recipient and no longer be protected by rule CFR 164.506 & 508;65 Fed. Reg. At 82509.

_____ _____

Printed Name of Patient and Guardian, if applicable Date Signed

_____

Signature of Patient and Guardian, if applicable