ENLIGHTENED INSIGHT

A HOLISTIC ECLECTIC PSYCHIATRY PRACTICE

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CONSENT TO RELEASE PROTECTED HEALTHCARE INFORMATION

Your Name (print clearly):____

I authorize Dr. Ulrick Vieux and any of his associates who may be directly or indirectly involved in my care to disclose confidential information about me to the persons/agencies listed below. This confidential information includes, but is not limited to: my alcohol and drug use history, psychological/psychiatric history, medical history; family history, legal and financial status, treatment history, results of diagnostic tests, urine tests, and clinical progress reports; current or planned treatment I may receive; all aspects of my treatment and clinical progress; and, all other information deemed important by Dr. Vieux to assist with my treatment and/or other personal or business matters including but not limited to insurance reimbursement, legal action, regulatory action, marital conflict, child custody, etc. *I authorize release of this information to the following persons, organizations, and/or agencies:*

Primary care provider(specify):_________________________ Your Initials:_____

Family member(specify):__________________________________Your Initials:_____

Others (specify): _______________________________________ Your Initials:_____

I acknowledge that this consent can be revoked by me in writing and that I can do so at any time for any reason except to the extent that: (a) this information is deemed necessary to protect my personal safety and/or the safety of others who may be seriously affected by my behavior; (b) disclosure has already occurred; and, (c) any pending action already taken and/or in progress that relies on this disclosure.

Patient’s signature:________________________________ Date signed:_______________