Bright Side Psychiatry

Jessica Halpern, MD
Specializing in Children, Adolescents & Women
608 Sherwood Parkway, Suite 106
Mountainside, New Jersey 07092
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jhalpern@brightsidepsychiatry.com

Authorization for the Use/Disclosure of Health Information

_____ _____
Patient's Name **Patient's DOB**

_____ _____
Street Address **Patient Phone Number**

_____
City, State & Zip Code

I hereby authorize the use or disclosure of protected health information about me as described below.

1. The follow person/class of persons/facility is authorized to use or disclose information about me:
   Jessica Halpern, MD/Bright Side Psychiatry LLC .

2. The following person/class of persons/facility may receive or disclose protected health information about me:

   _____
   Name of person/class/facility receiving disclosed information

   _____
   Street Address City, State & Zip Code

   _____
   Phone number

3. The disclosure pertains to all my health information that is in possession of the above named in Item #1, including information relating to any medical/social/legal history, physical condition, and any received treatment.

   Unless you initial here, no information about substance abuse, HIV/AIDS, or mental health will be disclosed:
   YES, disclose this information _____
   NO, do not disclose this information _____

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4. I understand that once Jessica Halpern, MD/Bright Side Psychiatry LLC discloses my health information, the above named in Item #2 could re-disclose my health information to third parties.

5. I understand that I may revoke this authorization by written notice to Jessica Halpern, MD/Bright Side Psychiatry LLC, except in extent any action that has already been taken in reliance upon this authorization.

6. This authorization expires on _____ OR upon occurrence of the following event that relates to me or to the purpose of the intended use or disclosure of the information about me: _____.

_____ _____
Signature of Patient **Date Signed**

_____ _____ _____
Signature of Guardian/Legal Representative (if patient is a minor) **Date Signed** **Relation to Individual**

A copy of this completed, signed, and dated form will be given to the patient/guardian/legal representative.