PSYMEDSOLUTIONS
Dr. Satish Narayan, M.D. & Dr. Nisha Satish, M.D.

Authorization to Disclose Health Information
Medical Records Release

______________________________ Patient Name (Please print)

______________________________ Date of Birth

______________________________ Social Security Number

______________________________ Phone Number

I HEREBY AUTHORIZE DISCLOSURE OF INFORMATION TO/FROM THE NAMED INDIVIDUALS OR ORGANIZATION(S) LISTED BELOW:

______________________________ Full Name or Person/Organization/Physician's Office
______________ Relationship to Patient
______________ Phone Number

[ ] Release all Health Information
[ ] Release all Billing Information (including payments, collections, etc.)
❑ DO NOT SPEAK/RELEASE INFORMATION TO ANYONE
[ ] Release Other (Please specify): ______________________________

______________________________ Full Name or Person/Organization/Physician's Office
______________ Relationship to Patient
______________ Phone Number

[ ] Release all Health Information
[ ] Release all Billing Information (including payments, collections, etc.)
❑ DO NOT SPEAK/RELEASE INFORMATION TO ANYONE
[ ] Release Other (Please specify): ______________________________

______________________________ Full Name or Person/Organization/Physician's Office
______________ Relationship to Patient
______________ Phone Number

[ ] Release all Health Information
[ ] Release all Billing Information (including payments, collections, etc.)
❑ DO NOT SPEAK/RELEASE INFORMATION TO ANYONE
[ ] Release Other (Please specify): ______________________________

- **I understand that incomplete forms will be null and void; no exceptions.**
- I understand that disclosure of my health information does not include mailing or faxing copies of my medical records; I must complete a medical records release in order to have copies of my medical records mailed or faxed to the named individual(s) or organization(s).
- I understand that specific information to be disclosed may include history of Drug or Alcohol Abuse or Mental Health Treatment, information concerning communicable diseases such as Human Immunodeficiency Virus (HIV), and Immune Deficiency Syndrome (AIDS), laboratory test results, treatment progress, and any other such related information. **This authorization will expire 1 year from the date of my signature.**
- I understand that the information released is for the specific purpose stated above. Any other use of this information without the written consent of the patient is prohibited.
- I understand that a revocation is not effective to the extent that the practice has relied on this authorization in its actions. Also, a revocation is not effective if this authorization was obtained as a condition of obtaining insurance coverage, as other law provides the insurer with the right to contest a claim under the policy or the policy itself.
- I further authorize that a photocopy of this authorization is acceptable as an original.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations.
- The practice will not condition my treatment, payment, and enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure. I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to: Privacy Officer: 7170 Preston Road Suite 200, Plano, TX 75024 Phone: 972-232-7474 Fax: 972-232-7401.

______________ Print Patient Name
______________ Patient/Guardian Signature
______________ Date
______________ Relationship

______________ Witness Signature
______________ Title
______________ Date

PSYMEDSOLUTIONS
Dr. Satish Narayan, M.D. & Dr. Nisha Satish, M.D.

SUBSTANCE USE	Age when first tried this:	How much & how often did you use this?	How many years did you use this?	Last use?	Do you currently use this?
ALCOHOL					Yes □ No □
CANNABIS: Marijuana, hashish, hash oil					Yes □ No □
STIMULANTS: Cocaine, crack					Yes □ No □
STIMULANTS: Methamphetamine (speed, ice, crank)					Yes □ No □
HEROIN					Yes □ No □
AMPHETAMINES/OTHER STIMULANTS: Ritalin, Benzedrine, Dexedrine					Yes □ No □
BENZODIAZEPINES/TRANQUILIZERS: Valium, Librium, Halcion, Xanax, Diazepam					Yes □ No □
SEDATIVES/HYPNOTICS/BARBITURATES: Amytal, Seconal, Dalmane, Quaaludes					Yes □ No □
STREET OR ILLICIT METHADONE					Yes □ No □
OPIOIDS: Norco, Vicodin, Lorcet, Lortab, Methadone					Yes □ No □
HALLUCINOGENS: LSD, PCP, STP, MDA, DAT, mescaline, peyote, mushrooms, ecstasy					Yes □ No □
INHALANTS: Glue, gasoline, aerosols, paint thinner, poppers, rush, locker room					Yes □ No □

Hospitalizations

Have you been recently hospitalized or participated in any outpatient programs? [ ] Yes (Complete Below) [ ] No

When: _____ Where: _____ Reason: _____

Lab Work

Please indicate which lab you prefer or that is in network with your insurance for blood work and/or Urinary Drug Analysis.

☐ LabCorp Laboratory Corporation of America ☐ Quest Diagnostics™ ☐ Other: _____

Drug Allergies

Please list any drug allergies and exactly how this medication affects you. (Examples: Rash, Hives, Itching, Swelling, etc.)

Medication Name: _____ Type of Reaction: _____

Medication Name: _____ Type of Reaction: _____

Pharmacy Information

Please list your pharmacy information. Please present a copy of your prescription card to the front desk.

Local Pharmacy Name: _____

City: _____ Pharmacy Number: _____ Fax Number: _____

Mail Order Pharmacy: _____

City: _____ State: _____ Pharmacy Number: _____ Fax Number: _____

PSYMEDSOLUTIONS
Dr. Satish Narayan, M.D. & Dr. Nisha Satish, M.D.

Medication Consent Form **Please list ALL of the medications that you take below.** **Medication Name, Strength and Directions**	Anti-Depressant	Anti-Anxiety	Psycho-Stimulant	Mood Stabilizer	Neuroleptic	Sleep Aide	Anti-Craving	Other
1.	☐	☐	☐	☐	☐	☐	☐	☐
2.	☐	☐	☐	☐	☐	☐	☐	☐
3.	☐	☐	☐	☐	☐	☐	☐	☐
4.	☐	☐	☐	☐	☐	☐	☐	☐
5.	☐	☐	☐	☐	☐	☐	☐	☐
6.	☐	☐	☐	☐	☐	☐	☐	☐
7.	☐	☐	☐	☐	☐	☐	☐	☐
8.	☐	☐	☐	☐	☐	☐	☐	☐
9.	☐	☐	☐	☐	☐	☐	☐	☐
10.	☐	☐	☐	☐	☐	☐	☐	☐

Please stop here. The remainder of this form will be completed in your visit with the physician.

EDUCATIONAL METHODS USED – Check all that apply.

☐ Verbal Explanation, specify if only method available. _____

☐ Other Written Materials, specify. _____

☐ Side Effects; specify medication and associated side effect(s). _____

_____

WOMEN OF CHILD BEARING YEARS ONLY – Check all that apply.

☐ I have been instructed in the safety of the above drugs in pregnancy. _____

☐ I have been informed of any above drug interaction which would interfere with the effectiveness of my birth control pill in current / future use, and the necessity to use alternate birth control measures. _____

_____

☐ If pregnant of breast feeding, I agree to discuss with my obstetrician or pediatrician before starting the medication(s).

I _____ have been instructed in the medication benefits, alternatives, side effects, and precautions of the above listed medications. My questions and concerns about the prescribed medication have been addressed and I agree to inform my provider if other questions and / or concerns should arise.

_____ _____

Patient/Guardian Printed Name Date/Time Patient/Guardian Signature Date

_____ _____

Nurse's Printed Name Date/Time Nurse's Signature Date

_____ _____

Provider's Printed Name Date/Time Provider's Signature Date