Dr. Michael A. Hernandez

Of MHernandez MD, PLLC

Coordination of Care Authorization to Release Confidential Information

Communication between your psychiatrist, primary care physician, therapist and/or other specialists is important to help ensure that you receive comprehensive and quality healthcare. This form will allow all persons/entities you list below to share protected health information between each other when necessary for your continuity of care. ***Please do not provide any persons/entities on this form that you do not wish to share information with this office.***

- Information will not be shared with any person/entity not listed on this form and will not be shared without your signature on this form authorizing such exchange.
- Information shared may include diagnosis, treatment plan, progress and medications as necessary.
- You may revoke this consent at any time by contacting this office, except to the extent that action has been taken in reliance upon it.
- This release will be valid (please check one):
  - ☐ Six months from the date of your signature below
  - ☐ Until revoked in writing by you
  - ☐ Other: _____
- You are not required to sign this release as a condition of treatment.
- You have a right to a signed copy of this signed release (please request if desired).

I hereby authorize the names/entities written below to release verbally or in writing information regarding any medical, mental health and/or alcohol/drug abuse diagnosis or treatment recommended or rendered to the below identified patient. I understand that this information is protected by federal and state laws governing the confidentiality of mental health and substance abuse records, and cannot be disclosed without my consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time and must do so in writing. A request to revoke this authorization will not affect any actions taken before the provider receives the request.

Patient Name: _____ Date of Birth: _____ Social Security #: _____

Psychiatrist: Michael Hernandez MD, 5440 Old Brownsville Rd, Corpus Christi, TX 78417-9765

Therapist: _____

Primary Care Physician: _____

☐ I do not have a PCP ☐ I have a PCP but choose not to allow communication with my PCP

Other Specialist: _____

Family Members: _____

Signature of Patient	Printed Name	Date

Signature of Parent/Guardian	Printed Name	Relationship	Date

5440 Old Brownsville Rd
Corpus Christi, TX 78417-9765
(361) 906-0166 (361) 994-7550