AUTHORIZATION FOR RELEASE OF INFORMATION

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Patient Rights

- You may end this authorization (permission to use or disclose information) any time by contacting our office.
- If you make a request to end this authorization, it will not include information that may have already been used or disclosed based on your previous permission.
- You will not be required to sign this form as a condition of treatment, payment, enrollment, or eligibility for benefits.
- You have a right to a copy of this signed authorization.
- If you choose not to agree with this request, your benefits or services will not be affected.

Patient Authorization

I, ____ (Birthdate _______________________),

hereby authorize Gary Peterson, M.D. ____ to exchange information with
____ to release information to
____ to receive information from

Name ____

Address, City, Zip ____

Telephone ___________________________ Fax ____________________________

These person(s) or entities may release verbally or in writing my protected health information (PHI) as selected below. I authorize the sharing of this information by mail, phone, in person, fax and/or email contact. I understand that these records are 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.

Disclosure Scope for PHI Release:

Disclosure may include the following verbal or written information: (check and initial all that apply)

- ☐ _____ Face sheet
- ☐ _____ Laboratory/diagnostic testing results
- ☐ _____ Discharge summary
- ☐ _____ Behavioral health/psychological consult
- ☐ _____ Emergency Department report
- ☐ _____ Substance abuse treatment records
- ☐ _____ Progress & Case Notes
- ☐ _____ Psychological evaluation/testing results
- ☐ _____ History & physical examination
- ☐ _____ School information
- ☐ _____ Medication records
- ☐ _____ Psychosocial assessment/Family history
- ☐ _____ Psychiatric evaluation
- ☐ _____ HIV/AIDS lab results & treatment history
- ☐ _____ Summary of treatment records & contact dates
- ☐ _____ Other: ______________________

☐ _____ Information necessary to identify, diagnose, establish prognosis, or describe treatment for mental health or substance abuse (alcohol/drug use), and any other relevant information for the purpose of treatment.

I understand this information will be used for ____ my clinical care ____ other __________________________________

This authorization expires: ☐ one year from the date of authorization
☐ 90 days after termination of treatment
☐ Other: _________________________________

I understand the concept of informed authorization. I understand the information to be released, the need for the information, and that there are statutes and regulations protecting the confidentiality of authorized information. I hereby acknowledge that this authorization is truly voluntary. I further acknowledge that I may revoke this authorization, in writing; at any time except to the extent the action based on this authorization has been taken.

____ *Signature of patient or legal representative*

_________________________________ *Date*

____ *Printed name of Signatory (if other than patient)*

_________________________________ *Relationship (if other than patient)*