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Consent to Release Information

Patient Name: _____ DOB: _____ Phone: _____

Address: _____ City: _____ State: ____ Zip: _____

I, _____, hereby authorize Diane Roth, PsyNP to ☐ send ☐ receive

the following information marked below ☐ to ☐ from:

Individual/Entity Name: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone: _____ Fax: _____

Documents to be released: ☐ Psychological testing results ☐ Lab reports
☐ Intake evaluation ☐ Progress notes
☐ Phone contact ☐ Other: _____

Purpose of release: ☐ Planning appropriate treatment or program
☐ Continuing appropriate treatment or program
☐ Determining eligibility for benefits or program
☐ Case Review ☐ Personal use ☐ Other: _____

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand the information disclosed to the recipient may not be protected under these guidelines if they are not a healthcare provider covered by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice. After 1 year, this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I am entitled to receive a copy of this authorization.

Client Signature: _____ Date: _____

Printed Name: _____ Relationship to Patient: _____

Provider Signature: _____ Date: _____
Diane Roth, PsyNP