Authorization for Release of Information

Instructions: Please read this form carefully and sign below indicating your agreement to its terms

Patient Name: _____Date of Birth: _____

I authorize Pioneer Peak Mental Health, Inc. to release information as stated below from the patient health information record:

Information to be Released From: Information to be Released To:

_____ _____

Information to be Released via: □ Email □ Fax □ Mail

Email/Fax Number/ Mailing Address: _____

Information to be Released: _____

Dates of service for information requested:

Beginning: _____thru _____

Purpose of Release: □ Continuing care □ Copies for own use □ Transfer to another provider

□ Legal □ Coordination with School □ Other:

I understand that:

- Authorizing the disclosure of this healthcare information is voluntary. I do not need to sign this form in order to assure treatment or payment.
- I can cancel this authorization at any time. I understand that once the information has been released according to the terms of this Authorization, the information cannot be recalled.
- Any disclosure of information carries with it the potential for further release or distribution by the recipient that may not be protected by confidentiality laws.

This Authorization will expire one year from the date signed below unless another date or event is entered here _____. A copy of this release shall have the same force and effect as the original.

Sensitive Records may require specific patient authorization. Please check the applicable box below to request the following records: □Mental Health Treatment □Sexually Transmitted Diseases
□AIDS/HIV Treatment □Alcohol/Drug Abuse Treatment

I understand that I have the right to revoke this authorization, in writing, at any time by sending notice to Linda Rasmussen, LCSW. I understand that a revocation is not valid to the extent that Linda Rasmussen, LCSW has acted in reliance on such authorization. It is your right to obtain a copy of this authorization. I understand that there is a potential for re-disclosure of this information by the recipient and, if that occurs, the information may not be protected by federal law.

_____ _____
Name of Responsible Party [print] Signature

Relationship to the Patient: _____ Date: _____

_____ _____
Client Signature (12 yrs. or older) Date Printed Name Date