AUTHORIZATION FOR RELEASE OF RECORDS

Patient Name: _____

Birth Date: _____

I hereby authorize :
Kimberly Butler, PMHNP
Bend Psychiatry
339 SW Century Drive, Suite 101
Bend, OR 97702
Phone: 541-382-1395 Fax: 541-382-6576

☐ Exchange Information ☐ Disclose Information only ☐ Receive Information only
(Initial one or more boxes above)

Release/Receive Information to/from: _____
(More than one may be listed. _____
If available provide address _____
phone number) _____

☐ Initial Psychiatric Evaluation
☐ Psychological Testing & Evaluation Reports
☐ History & Physical Exams
☐ Laboratory Data
☐ Progress Notes
☐ Treatment Plan/Summaries
☐ Discharge Summaries

☐ I also authorize the release of information pertaining to drug and alcohol abuse and mental health, if such is part of the medical record.

I understand that I may revoke this authorization at any time, except to the extent action has been taken based on this authorization before it is revoked. I understand this authorization will expire one year after the date.

I have read and understand this authorization. I have asked questions. About anything that was not clear to me and I am satisfied with the answers I have received.

X	
Patient Signature:	Date Signed:

If the patient is uanble to sign, indicate reason here: _____

Signature of person authorized to sign for the patient: X _____