Authorization to Release Confidential Records & Information

I, _____ _____
Patient name Street address

_____ _____
Phone number City State Zip code

_____ _____
Date of birth Social security number

authorize Brent Frazee, MD to disclose and/or receive protected health information to/from:

_____ _____
Person/entity name Street address

_____ _____
Phone number City State Zip code

This authorization for release of information covers the following period of healthcare:
☐ All past, present, and future periods
☐ From _____ to _____

I authorize the release of my complete health record, with the following exceptions:
☐ Mental health records
☐ Communicable diseases (including HIV and AIDS)
☐ Alcohol/drug abuse treatment
☐ Other (please specify): _____

The purpose of the information disclosed will be:
☐ To further mental health evaluation, treatment, and care
☐ Other (please specify): _____

I understand that:

I. This authorization shall be in force and effect until 90 days after the date on which it is signed, or until fulfillment of the above stated purpose(s), whichever is longer.
II. That I may revoke this consent at any time, that revocation must be made in writing to the address at the bottom of this form, and that revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization.
III. Information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____ _____
Patient name (printed) Patient signature Date