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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

PATENT NAME:_____ BIRTHDATE:_____

This will authorize Dr. Sethre to: _____ obtain from _____ provide to:

(Name of clinician/clinic):_____
Address: _____

The information to be disclosed limited to:
__ Intake Summary
__ Psychological Assessment Report
__ Interim Treatment Summaries
__ Discharge Summary
__ Medical treatment records
__ Phone consultation
Other:_____

This release is effective for services beginning:

I am requesting this information be released for the following purposes:
___ Coordinating care with other clinician/clinic
___Treatment planning
___ Other: _____

I understand that:

- **This authorization will automatically expire one year from the date of my signature.**
- **I may revoke this authorization at any time in writing, and revocation will not apply to information that has already been released in response to this authorization.**
- **Once information is released by Dr. Sethre to another clinician/clinic, he cannot prevent the re-disclosure of this information to another third party.**

_____ _____
Signature of Patient/Authorized Person Date