AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name_____

Date of Birth_____

The above-named person must indicate when this authorization is to expire:

____ When information is received ____ In one year

____ In six months ____ In three years

____ On date: _____

The person named above is or has been a patient of:

Dawn Nelson, LCSW-S, ACSW, SAP, CART
1024 Ridge Road
Rockwall, Texas 75087
972-989-2799

The person named above authorizes information to be requested from or released to representatives of:

Name of Person, Provider, or Facility _____

Address _____

Phone _____

Email _____

The person named above authorizes Dawn Nelson, LCSW-S, ACSW, SAP, CART, to:

____ Request health information from ____ Send health information to

____ Discuss health information with

Scope

____ All information regarding assessment, diagnosis, and treatment of patient's condition, concern, including:

_____(initial) Alcohol or Drug Abuse

_____(initial) Mental Health

OR specify other information:
_____

____ All information regarding care received by patient between the dates of (starting date) _____ and (ending date) _____

Authorization

Printed Name of Patient or Authorized Representative

_____

Signature of Patient or Authorized Representative

_____

Date _____

Signature of Witness

_____

If not signed by the patient, indicate relationship of authorizing person to patient:

____ Parent or guardian of minor child

____ Guardian or conservator of conserved patient

____ Beneficiary or personal representative of a deceased individual

The above person has the following rights:

- This authorization is effective for the above requested and authorized health care information only. You may ask for and receive a copy of this authorization form.
- This authorization will expire on the date you indicated above. Additionally, you may revoke this authorization at any time by submitting a written request to this office. Your revocation will be honored except to the extent that it has been acted upon in good faith while in force.
- You have the right to inspect the information you are authorizing to be released or disclosed by the recipient. We are not responsible for the actions of others who may be provided with information released as a result of this authorization.
- You may refuse to sign this authorization. Such refusal will not affect your ability to obtain treatment except to the extent that the information being requested may assist your health care provider in determining appropriate treatment.
- Please Note: Unless otherwise specified by law, we will release only that information which has been created by this office, including chart notes, summaries, and consultation reports. Records created and available from other providers or other care facilities must be obtained directly from those other providers or facilities.
- There may be a fee associated with the copying of your records. If for personal use, you are entitled to one copy free of charge. Additional copies for you, future releases to you, or releases to others may be subjected to a reasonable charge. Please ask the office for additional information about applicable copying fees.