Calhoun Consultants



AUTHORIZATION TO RELEASE INFORMATION *(13 and up)*

The following information on _____ _____
(Patient's Name) (Date of Birth)

☐ I authorize Dr. Kimberly Calhoun to request records from the following office:
☐ I authorize Dr. Kimberly Calhoun to release records to the following:
☐ I give Dr. Kimberly Calhoun permission to speak verbally with the following:

_____
(Name of Family or Clinician)

_____
(Address)

_____
(City, State, Zip)

_____
(Phone Number)

_____
(Fax Number)

☐ Private Clinician ☐ Hospital ☐ Court System ☐ Self

☐ Family member or support person ☐ Other

Please release the following information (or specify):

☐ ALL INFORMATION ☐ Medical Records

☐ Lab Results ☐ Medical History/Physical

☐ Psychologist Evaluation ☐ Discharge Summary

☐ Social History ☐ Verbal Information

☐ Treatment Plan/Patient Progress

☐ Results of Drug and Alcohol Treatment or Testing

☐ Other (specify) _____

_____

For the Purpose of: _____

Approximate Dates of Service: _____

Release Expiration Date: _____ ***Not to exceed 90 days*** (Consent subject to revocation at any time.)

This authorization provides that:

- I may revoke this authorization at any time, provided that the revocation is in writing to the Privacy Officer at this practice, except if this practice has taken action relying on this consent or if the authorization was obtained as a condition of obtaining insurance coverage.
- Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by HIPAA privacy rules.
- This practice will not condition treatment on my providing authorization for the requested use or disclosure.
- I have the right to access my protected health information to be used or disclosed.
- I will receive a copy of this completed authorization form showing when my records have been sent.

**** There is a standard processing fee of $35.00 for any medical records that are released. Also, all patient responsibility balances must be paid in full before any records are released. ****

_____ _____
Signature of Patient / Responsible Party if Minor Date

_____ _____
Signature of Witness Date

_____ _____
Signature of Clinician 1 Date

_____ _____
Signature of Clinician 2 Date

_____ _____
Signature of Clinician 3 Date

_____ _____
Date Records Sent Initials of Records Keeper

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