Laura J Dalheim, MD
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Authorization for Release of Information

Name _____ Date of Birth _____

Address _____

Phone _____ Email _____

☐ **I authorize Laura J Dalheim, MD to release information to:**

Name of Provider or Facility _____

Address _____

City, State, Zip Code _____

Phone #/Fax # (Include area code) _____

AND/OR

☐ **I authorize Laura J Dalheim, MD to obtain information from:**

Name of Provider or Facility _____

Address _____

City, State, Zip Code _____

Phone #/Fax # (Include area code) _____

Purpose of this request ☐ Healthcare ☐ Insurance Coverage ☐ Personal ☐ Other

Type of records authorized ☐ Psychiatric/Psychological Evaluation and/orTreatment ☐ Drug/Alcohol Evaluation and/orTreatment

Specific information authorized (select one or more as appropriate)

☐ Assessments ☐ Progress Notes ☐ Laboratory Test Results: ☐ Diagnostic Impression ☐ Discharge Summary
☐ Treatment Plans ☐ Treatment Summary ☐ Other: (please describe) _____

☐ **One-time Use/Disclosure:** I authorize the one-time use or disclosure of the information described above to the person/provider/organization/facility/program(s) identified.

My authorization will expire: _____

☐ **Periodic Use/Disclosure:** I authorize the periodic use/disclosure of the information described above to the person/provider/organization/facility/program(s) identified as often as necessary to fulfill the purpose identified in this document.

My authorization will expire: _____

I understand that:

- I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment.
- I may cancel this authorization at any time by submitting a written request to Laura J Dalheim, MD, except where a disclosure has already been made in reliance on my prior authorization.
- If the person of facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- If the authorized information is protected by federal confidentiality rules, it may not be disclosed without my written consent unless otherwise provided for in the regulations.
- Release of HIV-related information requires additional information.

Signature of Patient or Representative: _____ Date: _____

Relationship to Patient (if requester is not the patient): ☐ Parent ☐ Legal Guardian ☐ Other:

Patient or Representative has been provided a copy of this authorization: