CARLA HELLEKSON, MD, PLLC

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AUTHORIZATION TO EXCHANGE PROTECTED HEALTH INFORMATION (PHI)

I authorize *Carla Hellekson, M.D., PLLC* to ☐ release / ☐ obtain information from the records of:

Patient Name: ______________________ Date of Birth: ______________

INFORMATION TO BE EXCHANGED WITH:

Organization/Individual: ______________________

Mailing Address: ______________________

Telephone: ______________________ Facsimile: ______________________

I authorize my records to be faxed to the number provided above. **Patient Initials:** __________

INFORMATION TO BE EXCHANGED:

☐ Sleep Evaluation, PSG Reports, and Progress notes
☐ Outpatient psychiatric evaluation
☐ PT/OT reports
☐ Inpatient psychiatric discharge summary
☐ Psychological testing/assessment
☐ Laboratory/test reports
☐ Summary of medical or psychiatric history and treatment, including progress notes
☐ Psychiatric treatment/termination summary
☐ Chemical dependency records
☐ Crisis plan
☐ Treatment plan
☐ All records
☐ Progress notes for dates: ______________________
☐ Psychiatric medical notes for dates: ______________________
☐ Other: ______________________

FOR THE PURPOSES OF:

☐ Participation in psychiatric evaluation and/or treatment services
☐ Coordination of care between multiple providers
☐ Transfer of care to a new provider
☐ Other (please specify): ______________________

I understand that only the patient who has consented for care (including minors 13 years of age and older) can authorize for release of records. I understand that these records may contain information relating to HIV/AIDS, sexually transmitted diseases, and/or drug/alcohol abuse. I give my specific authorization for these records to be released. I understand that authorizing the disclosure of this health information is voluntary. I do not need to sign this form in order to assure treatment or payment. I understand that I can cancel this authorization at any time by writing to *Carla Hellekson, MD, PLLC*. I understand that once the information has been released according to the terms of this authorization, that the information can not be recalled. I understand that any disclosure of information carries with it the potential for further release or distribution by the recipient that may not be protected by federal confidentiality rules. I may cancel this authority at any time, except to the extent that action has already been taken. To revoke Authorization to Release Patient Health Information, I must do so in writing. Unless I cancel earlier, this authorization will expire when treatment with Dr. Hellekson has ended or one year after date of last visit, unless otherwise specified here: __

Patient Signature: ______________________ **Date:** ______________

The authorization below is given on the patient's behalf because the patient is either a minor or unable to sign.

Name: ______________________ Relationship to Patient: ______________________

FOR INTERNAL USE ONLY
Date Request Received: ______________________ Processed By: ______________________