

RELEASE OF INFORMATION AUTHORIZATION

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_  
E-mail Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**I request my protected health information (PHI) from Krystle Rowe be disclosed to:**

Recipient name: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_  
E-mail Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
Fax (healthcare provider only): \_\_\_\_\_

**I authorize the following PHI to be released from my medical record(s):**

Entire Record      Treatment Progress      Diagnosis      Test Results      Prognosis  
Dates of Treatment      Session Start/Stop Times      Treatment Plan or Goals  
· Other (please specify): \_\_\_\_\_

**Covering the period of healthcare from:** \_\_\_\_\_ **to** \_\_\_\_\_

**Purpose for disclosure of information:** \_\_\_\_\_

**Disclosure Format (Paper is default if not marked):** \_\_\_\_\_ US Mail (paper) \_\_\_\_\_  
Fax(healthcare provider only) \_\_\_\_\_ E-mail (secure) \_\_\_\_\_ E-mail (unsecure) \_\_\_\_\_  
\_\_\_\_\_ Other (please specify) \_\_\_\_\_

**By signing this authorization form, I understand that:**

- Request for copies of records are subject to reproduction fees authorized by state/federal law.
- I have the right to **REVOKE** this authorization at any time. Revocation must be made in writing and presented or mailed to: Krystle Rowe, 7177 Brockton Ave. #228, Riverside, CA 92506.

Revocation will not apply to information already disclosed in response to this authorization.

- Unless otherwise revoked, this authorization will **EXPIRE** on the following date/event/condition: \_\_\_\_\_

If I fail to specify an expiration date/event/condition, this authorization will expire one (1) year from the date signed.

- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized redisclosure.
- I have the right to receive a copy of this signed authorization. A copy or fax of this authorization is as valid as the original.

\_\_\_\_\_  
Signature of Patient/Authorized Representative      Relationship to Patient (if applicable)

\_\_\_\_\_  
Print Name      Date