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. #226, 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