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Authorization for use and disclosure of protected information

I, _____ ,

Date of birth: _____ Social Security Number _____

Address _____

_____

Phone _____

Authorize: Frauke C. Schaefer, MD (address as above)

☐ To release the following information to the person or entity below:

___ Psychiatric Records
___ Psychological Testing
___ Records of Psychiatric Hospitalization
___ Diagnostic & Laboratory Testing
___ Medical Records_____
___ Other _____

Regarding services rendered during the following dates: _____

☐ To receive information from the person or entity below

Name of treatment facility or clinician _____

Address: _____

City _____ State _____Zip_____ Phone _____

The purpose of this disclosure is for evaluation, treatment and continuity of care.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the treatment facility or clinician named above. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurance with the right to contest a claim under my policy.

I understand that this authorization for disclosure is voluntary and that I need not sign this form to ensure healthcare treatment.

This authorization will expire on _____ (if no date is entered it will expire in 12 months from the date signed).

Signed: _____ Date _____