Anita M. Katz, PMHNP
5410 SW Macadam • Suite 270
Portland, OR 97239
ph. (503) 764-9508 fax (503) 764-9558

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient's Name: _____Patient's Date of Birth: _____

I, _____authorize Anita M Katz, PMHNP to obtain information from and release information to:

Name/facility: _____

Address: _____

Phone: _____*Fax:* _____ *Email (secured):* _____

I specifically authorize release of the following:

Please sign your initials as appropriate

__ Drug/Alcohol Abuse Treatment
__ Psychiatric and Mental Health Treatment
__ Human Immunodeficiency Virus, Antibody Test and Results
__ Discharge Summary
__ History and Physical Assessment
__ Emergency Room Reports
__ Lab Results
__ EKG
__ Intake and Psychosocial Reports
__ Coordination of Care
__ Other-Specify: _____

The purpose of such information is: Patient Care.

I, expressly and voluntary authorized the disclosure of my medical records for the purpose stated above. I further understand that I am not giving permission for any disclosure other than described above. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken.

This consent may be revoked by me at any time, but may not be revoked in respect to information provided or actions taken prior to time of revocation. Unless expressly revoked earlier, expires one year from signature date.

Patient's Signature: Date:

Parent/Guardian Signature: Date: