Anita M. Katz, RN, MN, PMHNP

5200 SW Macadam Ave. Suite 312

Portland, Oregon 97239

Psychiatric Mental Health Nurse Practitioner

Office (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:

Provider's Name: _____

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: _____