PSYCHIATRY ASSOCIATES, PC

Jami Eschler, MD - Raven Lipmanson, MD

Jill Ridley, DNP – Victoria Valdesuso, PsyD, APRN – Karen Lundgren, LCPC

AUTHORIZATION TO RELEASE INFORMATION

2078 Stadium Drive, Ste 101

Bozeman, MT 59715

Phone (406)587-0810   Fax (406) 522-9975

NAME: ____ DOB: ______________________

SSN: ____

I hereby authorize Jami Eschler, MD, Raven Lipmanson, MD, Jill Ridley, DNP, Victoria Valdesuso, PsyD, APRN , and Karen Lundgren, LCPC to do the following:

- ❑ RELEASE TO
- ❑ OBTAIN FROM

Name: ____

Agency: ____

Address: ____

Phone: _________________________________ Fax: ____________________________________

Specific Information to be released or obtained (please initial):

- ❑ Psychiatric Evaluation/Records
- ❑ Progress Notes/MD Notes
- ❑ Lab Tests
- ❑ Radiology Reports
- ❑ Intake/Discharge Summary
- ❑ Other:____

I understand that this could include information related to treatment for alcohol and/or drug abuse

THE PURPOSE OR NEED FOR SUCH DISCLOSURE IS: ____

I voluntarily allow the above named agencies to disclose information to facilitate my treatment. I understand that this information will not be disclosed anyone other than those persons participating in my treatment without my written permission. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it (e.g. probation, parole, etc.) and that, in any event, this consent (unless expressly revoked earlier) expires as described below.

The facility, it's employees and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

I authorize the use of a telefax or photocopy of this from for the release or disclosure of the information described above.

This authorization is valid for a two year period from the date of signature, unless this form contains a specification of a Date, Event or Condition upon which this consent expires: ____

Client or Guardian Signature: ____ Date: ____________________

Witness Signature: ____ Date: ____________________