Julie Ryder, PMHNP
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Authorization for the Release of Confidential Information

Patient's Name _______________________________ Date of Birth ________________

I authorize **Julie Ryder, PMHNP**, to exchange/release/receive confidential information with/to/from:

Name: ____

Address: ____

Phone ____ Fax ____

For the purpose of: ____

Authorization Includes: (initial)

______ Psychiatric Evaluation
______ Treatment Plan
______ Diagnosis
______ Lab
______Progress Notes/Treatment Summary
______ Drug and Alcohol history
______ HIV status/STD's
______ Legal history
______ Medical history
______ Hospitalization/ER records

This authorization is valid for one year or until ____

I understand that my medical records are confidential and protected by law. I understand that information regarding psychiatric and chemical dependence history receives special protection under HIPPA laws. I have read and had an opportunity to ask questions about this document. I willingly consent to this agreement and have not been pressured to sign.

____ ___________________________
Signature Date

______ patient ______ parent ______ guardian ______ custodian