ERIN MCCARTHY SHAW
NPP, PLLC

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RELEASE OF INFORMATION

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION THIS IS A LEGAL DOCUMENT AND WILL NOT BE HONORED UNLESS IT IS COMPLETED IN FULL.

Name of Client: _____

Client's Date of Birth _____

Name of Person Completing this Form: _____

Relationship to client:

☐ Self

☐ Parent or Legal Guardian

☐ Other (describe) _____

Purpose of Release

☐ Evaluation and Treatment

☐ Emergency Communication

☐ Payments and Fees

☐ Other (describe) _____

I hereby authorize and/or request that the staff at Erin McCarthy Shaw, Nurse Practitioner in Psychiatry, PLLC:

Please check the applicable box:

Speak to: ☐ I agree ☐ I do not agree

Obtain records from: ☐ I agree ☐ I do not agree

Release records to: ☐ I agree ☐ I do not agree

Name of individual (e.g., therapist, family member) or organization (e.g., outpatient facility) with whom we may communicate: _____

Their address: _____

Their phone number: _____

Their email address: _____

Their fax number: _____

I understand that this authorization is voluntary and that information to be released/obtained may include medical, psychiatric, substance abuse, and/or HIV/AIDS treatment information unless otherwise specified:

I understand that refusal to sign this authorization form will in no way affect my right to obtain present

and future treatment, except where disclosure of such communications and records is necessary for treatment. I also understand that I may revoke this authorization at any time by written request, except to the extent that action has been taken in reliance on it. I further understand that the confidentiality of psychiatric, substance abuse, and HIV/AIDS records are protected under State and Federal Laws and cannot be disclosed without my written authorization unless otherwise provided for by law. The information disclosed by this facility pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal law. I understand that this authorization is voluntary and that information to be released/obtained may include medical, psychiatric, substance abuse, and/or HIV/AIDS treatment information unless otherwise specified above.

For how long should this authorization be in effect? _____ (Date not to exceed 12 months. If left blank, this authorization will expire 12 months from date of signature below.)

A copy of this authorization will be provided to the client or parent/guardian upon request.

Date signed: _____

_____ _____

Client Signature Date