# ARBOR PSYCHIATRIC AND WELLNESS CENTER

## RELEASE OF INFORMATION

| Patient Name (Last, First, MI) | DOB: |
|---|---|
| Patient Address | Phone Number |

I, or my legal representative, request that Lindsey Teten, APRN (provider) and/or Mindz, Inc. (business) disclose and/or exchange health information regarding my care and treatment with the individual or organization below:

Name: Auburn Family Health Center, PC

Address: 2115 14th Street, Suite 100, Auburn, NE 68305

Phone Number: 402-274-4993 Fax: 402-274-4905

1. Specific type of information to be released: (initial appropriate areas)
____ All records
____ Attendance records
____ Phone contact
____ Psychiatric Assessment & Update
____ Treatment Plan & Update
____ Psychosocial Assessment & Update
____ Medication Administration Record
____ Prescribers Orders
____ Discharge Summary
____ Other, please specify: _____

2. I am requesting the release of this information for the following purposes: (initial appropriate areas)
____ Information at the request of the individual
____ Coordination of services
____ Care/treatment
____ Treatment planning
____ Assessment/evaluation
____ To follow up regarding a referral
____ Other, please specify: _____

1. I understand that this authorization will not expire unless requested by patient/guardian.
2. I understand that I may revoke this authorization at any time by notifying Arbor Psychiatric and Wellness Center at the address indicated below, verbally or in writing, and this authorization will cease to be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations.
4. I understand that the following information may be disclosed upon singing this release: information related to substance abuse, mental health diagnoses and treatment, HIV related information.
5. I understand that my refusal to sign this Authorization will not jeopardize my right to obtain present or future treatment for psychiatric disabilities except where disclosure of the information is necessary for the treatment.
6. I understand that I can request a copy of this form after I sign it.

Signature of Patient or Legal Representative: _____ Date: _____

Printed Name of Legal Representative: _____ Relationship: _____

Witness: _____Date: _____