Touchstone LIFE CENTER
Child, Adolescent, and Adult Psychiatric Services

Authorization for Use/Release of Health Information

By signing this form, I authorize Dr. Kris Peterson MD TOUCHSTONE LIFE CENTER PLLC to use, release, discuss or disclose the protected health information described below to:

Name of Person and/or Organization to Whom Information Should be sent/contacted_____

Address of Person/Organization to Whom Information Should Be Sent _____

Please send this information on or about: (DATE/ AS SOON AS POSSIBLE)_____

Purpose of disclosure (at request of patient, medical care, etc.)_____

I authorize the following information to be discussed or sent to the address above:

Copies of all medical records for the period: Entire Record/time of treatment_____or Specify TIME:_____

Copies of the information described below for period ___/___/____ to ___/___/____

_____ENTIRE RECORD or ___ History & Physical Examination ___ Lab, X-ray, etc. Report ___ Reports from Other Physicians

_____NOTES ___ Other (Please Specify)

I understand that this information may include any history of behavioral health service/psychiatric care; treatment for alcohol and/or drug abuse; or similar conditions and or other personal information.

The following information should not be released, even if occurring during dates above –
_____

* Please describe any special requirements such as Faxing, certified mail, extended expiration date, and the like –

_____

I understand that there may be information in these records that I would not want released. I have been provided a copy of Touchstone Life Center PLLC, Notice of Privacy Practices and any charges that may be associated with this authorization. I have discussed any concerns I may have about the use, release, disclosure of my health information with Dr. Kris Peterson TLC PLLC or other appropriate office personnel. I understand that Touchstone Life Center/ Dr. Peterson assumes no responsibility for the use or misuse by others of my health information disclosed under this authorization. I release Dr. Kris Peterson and Touchstone Life Center PLLC from all legal liability that may arise from this authorization.

Patient's Signature _____Date _____

Print Patient's Full Legal Name _____

DOB:_____ Phone # _____

If the signature above is not that of the patient, I am acting for the patient because _____

My relationship to the patient is: _____. Signed _____

The patient or their representative may revoke this authorization by notifying in writing Dr. Kris Peterson Touchstone Life Center or his designated Privacy Officer. Federal law states that treatment, payment, enrollment, or eligibility for benefits may not be conditioned on obtaining this authorization if such conditioning is prohibited by the Privacy Rule. Federal Law also requires a statement that there is the potential for the protected health information released under this authorization may be subject to redisclosure by the recipient.